



## Empowering Women and Strengthening Health Systems and Services Through Investing in Nursing and Midwifery Enterprise: Lessons from Lower-Income Countries: Workshop Summary

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Patricia A. Cuff, Deepali M. Patel, and Megan M. Perez, Rapporteurs; Global Forum on Innovation in Health Professional Education; Forum on Public-Private Partnerships for Global Health and Safety; Board on Global Health; Institute of Medicine

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**Empowering Women and Strengthening  
Health Systems and Services  
Through Investing in  
Nursing and Midwifery Enterprise**

**Lessons from Lower-Income Countries**

WORKSHOP SUMMARY

Patricia A. Cuff, Deepali M. Patel, and Megan M. Perez, *Rapporteurs*

Global Forum on Innovation in Health Professional Education

Forum on Public–Private Partnerships for Global Health and Safety

Board on Global Health

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The serpent has been a symbol of long life, healing, and knowledge among almost all cultures and religions since the beginning of recorded history. The serpent adopted as a logotype by the Institute of Medicine is a relief carving from ancient Greece, now held by the Staatliche Museen in Berlin.

Cover photo © Chad Bartlett, courtesy of LifeNet International. L.N. Nurse Trainer Dorine Gahimbare is pictured on the left walking with Seraphine, a nurse at Gakwende Health Center, a LifeNet International partner health center in Southern Burundia. For more information about LifeNet International, visit <http://www.lninternational.org>.

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Willing is not enough; we must do.”*  
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This workshop summary has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the National Research Council's Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making its published workshop summary as sound as possible and to ensure that the summary meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the process. We wish to thank the following individuals for their review of this workshop summary:

**JULIE A. FAIRMAN**, University of Pennsylvania School of Nursing  
**ALLISON TUMMON KAMPHUIS**, The Procter & Gamble Company  
**PETRA TEN HOOPE-BENDER**, ICS Integrare

Although the reviewers listed above have provided many constructive comments and suggestions, they did not see the final draft of the workshop summary before its release. The review of this workshop summary was overseen by **Colleen Conway-Welch**, School of Nursing Vanderbilt University. Appointed by the Institute of Medicine, she was responsible for making certain that an independent examination of this summary was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this workshop summary rests entirely with the rapporteurs and the institution.



## Acknowledgments

The Institute of Medicine (IOM) Global Forum on Innovation in Health Professional Education and Forum on Public–Private Partnerships for Global Health and Safety would like to thank the workshop planning committee chair, Marla Salmon, for her leadership and her vision for this workshop topic. We also thank the planning committee members, Mary Barger, Lakshmi Karan, Gina Lagomarsino, Address Malata, Liesbet Peeters, Krishna Udayakumar, and Diệp Vương, for their hours of service in developing and superbly executing the final workshop agenda. The event would not have been possible without the participation of the workshop attendees who we thank for taking the time to attend this meeting and for contributing to the fruitful discussions captured in this summary report.

A number of individuals contributed to the development of this workshop and report. This event could not have happened without the keen dedication of the IOM staff of the Global Forum on Innovation in Health Professional Education, including Patricia Cuff, forum director, Megan Perez, research associate, and Bridget Callaghan, senior program assistant, as well as the IOM staff of the Forum on Public–Private Partnerships for Global Health and Safety, including Kimberly Scott, forum director, and Rachel Taylor, program officer. In addition, we thank the University of Washington staff, especially John Compton, as well as workshop rapporteur Deepali Patel. We also thank The Rockefeller Foundation Bellagio Center, Pilar Palacia, and Laura Podio for their generous support of this event. And most important, we acknowledge with deep appreciation the Robert Wood Johnson Foundation and in particular Deborah Bae, whose support of this topic made the workshop possible.



## Preface

Investment in women's enterprise as a means for their empowerment is a longstanding international development practice. These investments have most often focused on engagement in commercial and agriculture ventures. However, reports of the emergence of investment in innovative forms of nursing and midwifery practice enterprise in lower-income countries hold promise for even greater opportunity for women. Understanding these opportunities and their value to the well-being of women, their communities, and health systems and services globally and in the United States has become a central focus for my work over the past decade.

The prospectus for this workshop grew out of initial exploration of the topic during a Fall 2012 Rockefeller Foundation Bellagio Center Residency, and matured while working at the Institute of Medicine as the 2012-2013 Distinguished Nurse Scholar in Residence.<sup>1</sup> During that time, I explored the feasibility and desirability of innovative investment in nursing and midwifery education and practice enterprise as avenues of opportunity for women's empowerment, and strengthening health systems and services in lower-income countries. This work benefitted greatly from the expertise, ideas, and support of colleagues and organizations in and outside the

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<sup>1</sup> The Institute of Medicine/American Academy of Nursing/American Nurses Foundation/American Nurses Association Distinguished Nurse Scholar in Residence.



Institute of Medicine (IOM),<sup>2</sup> and the inspiration and experiences of the nurses and midwives I have been privileged to know over the many years of my work in global health. The culmination of these efforts led to two major personal conclusions: (1) investment in nursing and midwifery enterprise can improve the lives of women associated with these innovations, those they serve, and strengthen health services/systems; and (2) the experiences of lower-income countries where rapid growth of investment in innovative nursing and midwifery enterprise is taking place have value to informing developments globally and in the United States.

This global workshop provided a unique opportunity to bring these conclusions into sharp and critical focus through the engagement of international thought leaders from multiple sectors. Their perspectives and insights bring much greater clarity to this important topic, and set the stage for the way forward that moves well beyond my initial explorations. Their contributions and the potential downstream benefit are significant and go well beyond my greatest hopes for this work.

The workshop and this report also reflect the important and unique capacity of the IOM to encourage and support critical exploration, deliberation, and exchange, and to share what is learned in ways that inform and advance the health of people worldwide. I deeply appreciate the remarkable opportunity of their engagement in this project—and the great privilege of collaborating with the staff who helped to make this work possible.

Marla Salmon, *Chair*  
Workshop Planning Committee

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<sup>2</sup> My deep appreciation to the individuals and organizations in the Acknowledgments, and for the University of Washington, Evans School of Public Affairs and the School of Nursing; the Center for Health Market Innovation; the American Association of Colleges of Nursing; the American Nurses Foundation; the American Nurses Association; and the Center for Health Market Innovation.

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	<i>Oscar F. Picazo, Valerie Gilbert T. Ulep, Ida Pantig, Danica Ortiz, Melanie Aldeon, and Nina Ashley de la Cruz</i>	

## Acronyms and Abbreviations

AAAQ	availability, accessibility, acceptability, and quality
BOP	bottom of the pyramid
CHMI	Center for Health Market Innovations
GDP	gross domestic product
GHILP	Global Health Investment Landscaping Project
GHWA	Global Health Workforce Alliance
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
HMI	Health Market Innovations
ICM	International Confederation of Midwives
ICS Integrare	Instituto de Cooperación Social Integrare
ICT	information and communications technology
IOM	Institute of Medicine
IPiHD	International Partnership for Innovative Healthcare Delivery
IUD	intrauterine device
K-MET	Kisumu Medical and Education Trust

MBBC	Mother Bles Birthing Clinic
MCF	Medical Credit Fund
mHealth	mobile health
MOH	Ministry of Health
NFP	Nurse–Family Partnership
NGO	nongovernmental organization
NORWAC	Norwegian Aid Committee
OECD	Organisation for Economic Co-operation and Development
PALS	Pacific Links Foundation
PEPFAR	U.S. President’s Emergency Plan for AIDS Relief
PIDS	Philippine Institute for Development Studies
PPP	public–private partnership
PSPI	Population Service Pilipinas, Inc.
R4D	Results for Development Institute
RWJF	Robert Wood Johnson Foundation
SEAD	Social Entrepreneurship Accelerator at Duke
SME	small or medium enterprise
TANGO	Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Services by Philippine NGO
UCLA	University of California, Los Angeles
UHC	universal health coverage
UNDP	United Nations Development Programme
UNICEF	United Nations Children’s Fund
USAID	U.S. Agency for International Development
UW	University of Washington
WFMC	Well-Family Midwife Clinic
WHO	World Health Organization
WIN WIN	Women Investing in Women Initiative

## 1

Introduction<sup>1</sup>

On September 9–11, 2014, the Global Forum on Innovation in Health Professional Education and the Forum on Public–Private Partnerships for Global Health and Safety of the Institute of Medicine convened a workshop on empowering women and strengthening health systems and services through investing in nursing and midwifery enterprise at the Rockefeller Center in Bellagio, Italy. Experts in women’s empowerment, development, health systems’ capacity building, social enterprise and finance, and nursing and midwifery explored the intersections between and among these domains. Innovative and promising models for more sustainable health care delivery that embed women’s empowerment in their missions were examined. Participants also discussed uptake and scale; adaptation, translation, and replication; financing; and collaboration and partnership.

What this report does not address are the precise quality measures of clinical skills and practice that could lead to a successful enterprise. The report also does not focus on specific educational requirements or individual competencies needed for developing entrepreneurial skills and how to identify personality traits of successful entrepreneurs. While these aspects are important for promoting businesses, they were not emphasized at the

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<sup>1</sup> The planning committee’s role was limited to planning the workshop. The workshop summary has been prepared by the rapporteurs (with acknowledgment of the assistance of staff as appropriate) as a factual account of what occurred at the workshop. Statements, recommendations, and opinions expressed are those of individual presenters and participants and are not necessarily endorsed or verified by the Institute of Medicine. They should not be construed as reflecting any group consensus.

workshop and therefore do not appear in this summary report. Instead, the report highlights examples and explores broad frameworks for existing and potential intersections of different sectors that could lead to better health and well-being of women around the world and how lessons learned from these examples might be applied in the United States.

## WORKSHOP OBJECTIVES

Workshop participants came from different countries with unique cultures, histories, and systems of government, finance, education, and health care. This diversity of perspectives enriched the discussions on women's empowerment and health systems strengthening through investment, innovation, and enterprise in nursing and midwifery. Examples from low- and middle-income countries, where significant developments in nursing and midwifery practices are taking place, were discussed as a means of exploring transferability of innovations from countries with low financial resources to higher-income countries—in particular, the United States. The workshop was designed to illuminate approaches that do and could empower women and strengthen health systems through targeted investments in social entrepreneurship of nurses and midwives (see Box 1-1).

### **BOX 1-1** **Statement of Task**

An ad hoc committee under the auspices of the Institute of Medicine will plan a 2-day public workshop that is aimed at exploring, explaining, and informing translation of models and lessons learned relating to innovative investment in nursing and midwifery training and enterprising practices as avenues for empowerment of women and strengthening of community-based health services in lower-income countries. Presentations and discussions will also explore ways in which these models might be advanced globally to better achieve the social mission of the health professions and to explore their relevance and potential application in the United States.

This global workshop, to be held at the Rockefeller Bellagio Center in Italy, will convene experts in the areas of women's empowerment and development, health systems' capacity building, social enterprise and finance, and nursing and midwifery. The committee will organize and conduct the workshop, select and invite speakers, and moderate sessions at the workshop. Following the conclusion of the workshop, an individually authored summary of the presentations and discussions will be prepared by a designated rapporteur in accordance with institutional guidelines.

This summary provides a synthesis of the presentations and discussions that took place at the workshop, and should not be construed as a consensus document. All statements are attributed to the individuals who spoke them. It should be further noted that in an effort to create a smoother flow of the statements made at the workshop and captured in this report, not all of the text follows the chronological order in which the discussions took place or appears in the agenda found in Appendix A.

## WORKSHOP OVERVIEW<sup>2</sup>

While nursing and midwifery are different disciplines, they have common characteristics that can provide a platform for service flexibility and responsiveness in health systems. Marla Salmon stated that both disciplines offer capacity for expansion and breadth through generalist roles, or contraction and depth through specialization. In addition, nurses and midwives are often deployed strategically to meet the needs of vulnerable populations in a variety of contexts, as well as for ongoing services to others. Important contributions made by nurses and midwives help communities meet their overall health needs. Such contributions include supporting patients in navigating complex health care systems and working at the interface between communities and public services. Their wide distribution and relatively greater numbers along with their proximity to and engagement with their communities ideally position nurses and midwives to have a significant influence in maintaining the health of the communities they serve (WHO, 2014).

As both public and private sectors seek to find cost-effective solutions to health challenges around the world, nurses and midwives are increasingly called upon to provide an even greater depth and breadth of services. At times, said Salmon, this has resulted in improved access to services for their clients and their communities, as well as increased opportunities for enhancing their own status and well-being through greater autonomy, broadened scopes of practice, and even ownership or operation of their own enterprises.

Categories for nursing and midwifery enterprise include provision of general and specialty direct services as well as indirect care support and coordination services such as scheduling medical procedures, charting patient progress, and providing effective communication between families and social service providers. Customers can range from patients and communities to governments, industries, or other health and nonhealth workers. These enterprises can offer clusters of services—such as primary care,

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<sup>2</sup> This section summarizes information presented by Marla Salmon, University of Washington (UW).



home health, or women's health—or single services, such as circumcisions or postabortion care. Additionally, partnerships with other care providers could expand their breadth and reach of services and potentially build a larger and more robust business. Nurses and midwives would benefit from the support and economies of scale offered through these arrangements.

Salmon stated that opportunities for nursing and midwifery enterprise are often associated with provision of services in rural or underserved areas, overlooked or emerging diseases or populations, or in relation to activities not traditionally associated with physicians or other providers (such as maternity or elder care). These areas provide opportunities for entrepreneurship and ownership, particularly in community-based settings. By expanding their traditional scope of services, nurses and midwives could build practices in areas that require strong coordination and collaborative skills; for example, this could include housing-based services for managing the care and support of vulnerable families, pharmacy-based services linking care to medication analysis and delivery, or early childhood-based services for special health care needs. These examples, which broaden the scope of practice while taking advantage of distinctive assets and skills of nurses and midwives, could open new opportunities for unique enterprise.

The convergence of growing investment and innovation in nursing and midwifery enterprise is also creating opportunities for empowerment of women. Both disciplines are female-dominated professions and directly impact the health and well-being of women, Salmon said. Workshop participants discussed the elements of women's empowerment associated with enterprise, noting that such opportunities are not only for nurses and midwives, but also those they serve and work with, including the community and their organizations. Becoming a nurse or midwife has transformative potential through the opportunities of greater education and training, knowledge and skills acquisition, social and economic mobility, earnings, and political and professional voice. Opportunities associated with enterprise can expand the possibilities for empowerment, including asset acquisition, ownership, and expanded possibilities for leadership and decision making. Empowered nurses and midwives can also provide enabling opportunities for the development of other women, including mentorship, supervision, training, and career progression. Additionally, there is potential for impact through caring, coaching, and connecting to health-related work. They can also serve as inspiration and resources to other women and girls in the community, including inspiring entrance into nursing or midwifery careers and providing informal health information and care.

How can this potential be realized? Participants brought together the domains of nursing and midwifery and women's empowerment in discussing innovations and investments for improving health care delivery. As populations grow and age, existing health systems cannot continue to

provide the same level of care to everyone they serve. At the same time, many gaps in coverage continue to exist. While emerging technologies can help expand the reach and reduce cost, capitalizing on lower-cost—but high-quality—workforce elements can also play a role. Embedding women's empowerment in the ownership or operation of their own enterprise, whether through a traditional delivery method or an innovative one, could be an avenue for a nurse or midwife to have a significant positive effect on health and society.

There is a convergence of forces at work, said Salmon, that make nursing and midwifery particularly critical at this moment in time: overtaxed health systems, growing unmet health needs, recognition of the importance of women's development to health and societal well-being, growing public- and private-sector engagement, increased investment in the health sector, and expansion of innovative models of service. In addition, within the global context, the health and development agendas are becoming intertwined as countries see the importance of this in order to advance society. She said that organizing and supporting nursing and midwifery enterprise ultimately has the possibility for several gains. Strengthened health systems and health services lead to improved health, and increased women's well-being and empowerment can lead to gender equity, economic and social well-being, and stronger societies.

## LAYOUT OF THE REPORT

The chapters of this report, divided into 3 parts, comprise accounts of the presentations and discussions that took place at the workshop. Speakers whose remarks are noted in the report were identified by the workshop planning committee members (see page v), who were instrumental in determining the focus of the workshop.

Part I (Chapter 2 and 3) lays the foundation for understanding the various elements as described by Salmon in her overview of the workshop. More specifically, this section examines the impact targets of nursing and midwifery, which are women's empowerment (Chapter 2) and strengthening of health systems and services (Chapter 3). The intentionality of women's empowerment is a theme that resonated throughout these chapters and the entire workshop.

Part II (Chapters 4, 5, 6, and 7) begins with an overview of nursing and midwifery education and enterprises, as well as a section exploring how social business models can be used to empower women (Chapter 4). Chapter 5 includes specific country perspectives on the issues covered in the previous chapters, delving into the issues encountered in Palestine, Nigeria, and the United States. Examples of innovations and strategies used to strengthen health systems and invest in women-owned health enterprises and global

health enterprises are explored in Chapter 6. Chapter 6 also includes the findings of a paper by Carleigh Krubiner, Marla Salmon, and Gina Lagomarsino; the authors used the Center for Health Market Innovations database to identify programs in low- and middle-income countries that address empowering women through nursing and midwifery. Chapter 7 examines social enterprises and how to scale impact, looks at some best practices for investing in health, and discusses investment models, such as franchises, for nursing and midwifery organizations or clinics.

Part III (Chapters 8 and 9) first explores how to transfer the models and lessons learned across national and international boundaries (Chapter 8). Possible challenges and opportunities are outlined, as well as strategies for transferring models globally and to the United States. Lastly, Chapter 9 discusses themes raised throughout the workshop and potential next steps for the way forward.

Appendixes A, B, and C include the agenda for the workshop, the speaker biographies, and the list of workshop participants, respectively. Appendix D is a paper written by speaker Oscar Picazo and colleagues, which describes in more detail four major innovations using nurse and midwife empowerment in the Philippines.

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# Part I



## 2

# Women's Empowerment

### Key Messages

When you think about planning for empowerment you also have to think about resources that have to be devoted solely for that purpose and incorporating them into an otherwise complex situation of changing the delivery system.

—Diệp Vương

Women-owned clinics . . . [have] even more additional complications. In many of the countries, you need collateral. For collateral you need property rights. You need to have your title deeds. You need to own your business. Often these women do not own anything. Their husband owns it, or their father.

—Monique Dolfig-Vogelenzang

Gender has the ability to knock down verticals. Investing in women is a way to cut across traditional silos such as agriculture, health care, and environment, and to empower women through multisector approaches.

—Beth Bafford

Women's lack of power in financial and political domains has resulted in a global gender imbalance that has far-reaching implications at individual, family, and societal levels. Empowering women improves the health of women and their family, builds linkages within communities, and promotes economic development. Participants discussed the means by which women can be empowered, particularly through increasing their economic participation, and shared potential future areas for investment.

### WOMEN'S EMPOWERMENT: INTENTIONAL INCORPORATION<sup>1</sup>

Diệp Vương cited The World Bank definition of *empowerment* in her opening remarks:

Empowerment is the process of increasing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes. Central to this process are actions that both build individual and collective assets, and improve the efficiency and fairness of the organizational and institutional context that govern the use of these assets. (World Bank Group, 2011)

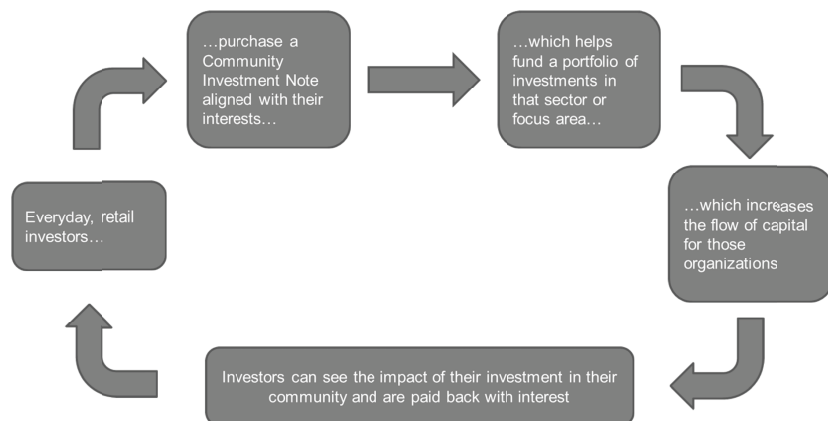
She emphasized that the elements of “capacity to choose,” “building individual and collective assets,” and the “context that governs the use of these assets” deserve specific attention. She noted that it would be possible to achieve innovative models of health care delivery without incorporating empowerment approaches, but she cautioned that they might not be long-term or sustainable models. Rather, she recommended not only to include empowerment, but also to recognize the need to devote resources solely for that purpose.

This involvement also should reflect appropriate participation and representation. Vương noted that even when disciplines are predominantly composed of women, men often hold higher-ranking and higher-paid positions of leadership. To ensure adequate participation of women, she asserted that a key element is asset building, including soft assets such as skills and knowledge or harder assets such as funds. In terms of skills, she said it is particularly important to distinguish between the role of a nurse or midwife as a professional delivering care and services and the traditional perspective of women in nurturing positions.

Empowerment of women also means empowerment of the community. For the provision of health care, this includes training providers within communities who come from those communities. Vương shared a story of trying to obtain care for a client in a rural town with limited options. The

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<sup>1</sup> This section summarizes information presented by Diệp Vương, Pacific Links Foundation (PALS).



**FIGURE 2-1** Social impact investing.  
SOURCE: Bafford, 2014.

local physicians offered one very expensive and invasive procedure to treat her, so Vuong and her client raised funds to travel to the city for a second opinion. It was there they discovered another less invasive and less expensive alternative that they elected to pursue. Vuong believes that this lack of health care choice for underserved populations is an opportunity for nurses and midwives to provide missing services to rural and other disadvantaged communities. She also asserted that even though provision of care is often limited by constrained resources, many times there is still an opportunity to create a marketplace for affordable health care with customers who have the ability to pay.

## INVESTING IN WOMEN'S EMPOWERMENT<sup>2</sup>

The Calvert Foundation is an impact debt provider based in the United States, Beth Bafford explained. As a nonprofit organization, it issues and deploys debt capital. The capital is pooled into funds that are invested in communities both in the United States and abroad via community development financial institutions, which finance ventures such as health clinics, community centers, affordable housing, small businesses, microfinance, and fair trade (see Figure 2-1).

Bafford noted that a few trends are occurring in the investment space.

<sup>2</sup> This section summarizes information presented by Beth Bafford, Calvert Foundation.



First, a huge wealth transfer—almost \$40 trillion—will happen over the next decade to millennials, who care about aligning their spending with their values. Secondly, crowdfunding is currently a popular topic; it connects people in a more direct way to the outcomes they are funding. Thirdly, investing based on values has led to the growth of socially responsible investing and impact investing, which had traditionally been inaccessible via previous modes of investment. Lastly, she said that there is an increased need for private capital in communities where government funding has been diverted.

### **The Women Investing in Women Initiative**

The Calvert Foundation has concentrated on innovative investment products that intentionally focus on women and their empowerment. Women Investing in Women Initiative (WIN WIN) is one such approach, which aims to more directly align similar values between investors and recipients. It is not only a community development finance initiative, Bafford explained, but also a means of creating a portfolio with a more specific identity. WIN WIN began as a pilot, with an initial capitalization of \$20 million raised from investors interested in women's economic empowerment. The second half of the initiative—identifying organizations for investment—was more complicated. Bafford noted,

[It was a] balance between rigor (academic and intellectual rigor) and flexibility for our borrowers. People look to us to have rigor in how we look at impact and how we evaluate the impact of our work. But we also have borrowers who do not want to be tied down by the burden of impact metrics that do not align with their ways of doing business.

To receive financing from the initiative, organizations had to meet one of two criteria. The first is the organization supports women—the majority of clients are women, there is a mandate to serve women in its mission, there is a specific program targeting women within the organization, or the majority of the organization's products or services are beneficial to women. The second is the organization has women's empowerment related services—there is adequate female representation on leadership teams or boards, or the organization has received industry-wide recognition for working with women. The Calvert Foundation also created a third option to individually select programs they felt were empowering to women.

### **Outcomes and Lessons Learned**

Bafford shared some of the outcomes of the program with workshop participants. She said there are 850 new investors, with 83 percent investing

online. Additionally, the new initiative reached a younger, predominantly female market; Bafford explained that this demographic shift provides possible opportunities for reaching younger generations to educate them about investing for social impact early in their careers. \$20.1 million was deployed into 16 organizations that financed more than 160 small businesses. Seventy-five percent of the borrowers had a majority female management, with investments in affordable housing, financial inclusion, environment, and health care.

There were some important lessons learned as well. Bafford said there is power in investment, particularly in converting individual assets into something that is aligned with values. There is also latent demand; individuals want to invest in women and need to be given ways to do so. Another lesson learned was that investing in women is a way to cut across traditional silos such as agriculture, health care, and environment, and to empower women through multisector approaches. Lastly, she said, portfolio creation should be inclusive and aspirational, and should strike a balance between ensuring fidelity to portfolio investment goals and maintaining flexibility to grow and adapt.

### SOCIAL ENTERPRISE AND WOMEN'S EMPOWERMENT<sup>3</sup>

Monique Dolfing-Vogelenzang described the PharmAccess Group, a Dutch organization started to provide access to HIV/AIDS treatment in Africa, in a time when no such treatment was provided due to complication and expense. PharmAccess fills similar gaps today—health insurance provision in community-based care, introduction of quality standards, health care investment via loans, and consulting with public–private partnerships.

#### The Medical Credit Fund

Within the PharmAccess Group, Dolfing-Vogelenzang heads the Medical Credit Fund (MCF), whose mission is to enable primary health care providers to access capital to improve quality of care and expanded services. In some low-income settings, she said, local government cannot always provide all of the services, and the private sector is often the default provider. But these private health care facilities are underfunded and lack access to capital, either locally or through donors. She noted there are a number of reasons for this, including weak financial and administration structures, but other reasons include collateral and contractual issues common to small and medium enterprises particularly in health care.

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<sup>3</sup> This section summarizes information presented by Monique Dolfing-Vogelenzang, PharmAccess Group.

### *Risk Reduction Programs*

The MCF, together with PharmAccess, has developed two risk reduction programs. The first is a medical upgrading and business plan to improve quality and efficiency and assessment of results, called SafeCare (further discussed in Chapter 6). The second is a financial program, which is a step-by-step approach to accessing capital at banks at affordable terms and conditions to enable expansion of services.

The two programs are linked and offered through local partners to build capacity through health networks and to provide loans. Loans are provided in amounts ranging between \$5,000 and \$350,000 with reasonable terms and partial guarantee through the MCF (with the local banks increasingly taking on risk). The MCF works with loan recipients to create business plans, increase efficiency, and guide investment toward quality issues. The fund also works with local implementing partners, such as local nongovernmental organizations, international franchise organizations, and associations of doctors. It is a hybrid fund with international investors, and its risk is reduced by the inclusion of donor funding from entities such as the U.S. Agency for International Development (USAID) and the Dutch government.

### *Challenges*

Currently, the MCF has funded almost 600 loans, with 26 percent of them made to enterprises headed by women. At the same time, women make up the bulk of the staff in a lot of male-headed clinics. Dolfing-Vogelenzang noted that there are additional challenges faced with women entrepreneurs:

- Collateral, usually property, is often required to obtain a loan. However, in many countries, women cannot exercise property rights.
- Lack of financial and business education poses a barrier to small business owners, particularly women.
- Midwife facilities are often located in rural areas, where there are few banks and the threshold for obtaining a loan is higher.
- Clinics are usually small, often run by one woman who needs to be in place to provide services and who cannot easily attend business trainings.
- Professional associations usually lack a strong secretariat, without which donors are not encouraged to provide funds.

### Examples of Enterprises

In her remarks, Dolfing-Vogelzang provided additional information about three of their partners and projects. One is the Kisumu Medical and Education Trust (K-MET) that is a network of more than 300 clinics throughout Kenya that provides health services to women. The second is a public–private partnership (PPP) between PharmAccess and the Ghanaian Ministry of Health for addressing a shortage of maternal health services in rural areas by setting up midwife franchise clinics in Ghana. This example is described in Box 2-1. The third involves a mobile health payment system that entails three critical steps as outlined in Box 2-2.

#### *Kisumu Medical and Education Trust (K-MET)*

K-MET was started by midwife Monica Oguttu with seed capital in the west of Africa. K-MET provides training in Kenya and other parts of East Africa and has built a network of clinics for improving women's health. One of their focuses is quality improvement, and they also saw the need to be able to support their network members (clinics) to access additional capital to grow and improve their quality. The MCF provided that capital, and in partnership they have supported more than 200 clinics in quality improvement. K-MET has also trained more than 1,000 community health workers and established Sisterhood for Change (shown in Figure 2-3) to empower girls in education.

#### *Midwife Franchise Clinics in Ghana*

PharmAccess and the Ghanaian Ministry of Health are working to establish a public–private partnership to develop a network of private maternity clinics in peri-urban and rural areas. This is a for-profit franchise model in which individual midwives are provided with standard guidelines, procedures, and a business model to develop their practice.

#### *Mobile Money and mHealth (Mobile Health) in Kenya*

PharmAccess is developing a health care payment infrastructure as a way for consumers to finance their health care needs by making use of the rapidly developing mobile payments market. This would be used at accredited facilities that provide a certain level of care, and would allow channeling funds for specific health benefits to beneficiaries through a mobile wallet. PharmAccess believes that this innovation will be a mechanism for pooling resources, and would also empower both patients and facilities to increase access to and improve quality of services.

## **BOX 2-1**

### **PPP Midwife Franchise Clinics Ghana<sup>a</sup>**

#### *Introduction*

PharmAccess and the Ghanaian Ministry of Health are planning a public–private partnership (PPP) to address the shortage of maternal health services in rural areas. The investment concerns the establishment of a network of private maternity clinics.

#### *Background*

Despite significant investments, maternal mortality in Ghana is still high with 350 per 100,000 live births. Of the 800,000 deliveries per year, only 48 to 60 percent are currently attended by a skilled health worker (see Figure 2-2). This is due to a shortage of supply of maternal health services, especially in the rural areas. Over the last years, the Ghanaian government has increased the training capacity for midwives to 1,500 per year, but they have limited employment opportunities.

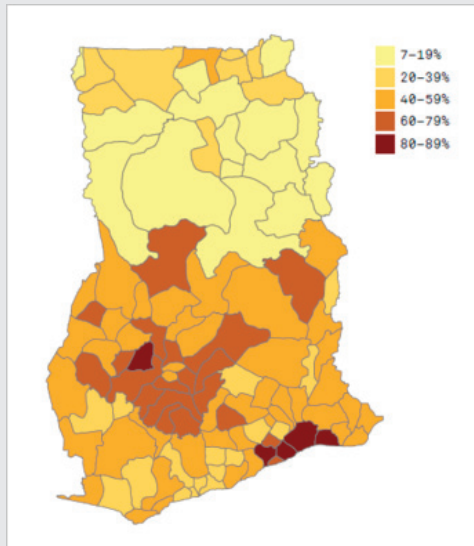
The PPP aims to address this issue by providing midwives with the opportunity to set a viable private midwifery practice in these rural areas. The government of Ghana intends to contribute to some of the operational expenses of the clinics, while fees are to be paid for by the National Health Insurance Scheme.

#### *The Investment*

The initial investment considers a combination of debt and equity into the private enterprise supporting the network and the provision of debt to the midwife entrepreneurs to co-finance their investment in the clinics. The private enterprise will provide support services to the clinics against a fee (e.g., training, information and communications technology, purchasing, quality control)—partly covered by the government—and act as a franchisor.

#### *Social and Economic Impact*

The partnership has a high social and economic impact in various areas that include



**FIGURE 2-2** Assisted deliveries in Ghana.

SOURCE: Dolfing-Vogelenzang, 2014. Material original to PharmAccess.

- Increasing the availability of quality maternal health services with an accompanied increase in skilled birth attendance. With 20 clinics, the network is expected to handle 6,000 deliveries per year, largely in low-income populations, which will likely decrease maternal and child mortality.
- Improving employment opportunities for midwives in rural areas in Ghana thereby reducing brain drain of health workers to urban areas and abroad.
- Setting an example for public-private partnerships in priority health areas in developing countries.

<sup>a</sup> The text in this box is reprinted with permission from Dolfing-Vogelenzang, 2014. SOURCE: Dolfing-Vogelenzang, 2014. Material original to PharmAccess.

**BOX 2-2****Mobile Health: An Integrated Approach, Empowering Patients<sup>a</sup>****Step 1: Health Payment Infrastructure**

- Create mobile health payment infrastructure to allow pooling of various sources of funds; (group) savings, remittances
- Improve business case for health care providers to invest in quality

**Step 2: Quality Standards**

- Establish national system for quality assessments using SafeCare standards
- Embed quality in the public system through cooperation with National Hospital Insurance Fund and Ministry of Health

**Step 3: Investments**

- Invest in quality and business improvement of private health care providers through the MCF
- Build the business case for private investments in the health sector

<sup>a</sup> The text in this box is reprinted with permission from Dolfig-Vogelzang.  
SOURCE: Dolfig-Vogelzang, 2014. Material original to PharmAccess.



**FIGURE 2-3** Sisterhood for Change.  
SOURCE: K-MET, n.d.

## IMPORTANT LESSONS IN WOMEN'S EMPOWERMENT

Participants discussed further challenges and opportunities in investing in women and their empowerment, which include

- Identifying the gap between the development of an innovation and its scale-up: Often new innovations are identified and applauded, but without a specific plan for scalability and expansion, they cannot grow.
- Bringing investors and donors to patients in a more direct way: Some current innovations seek to match patients with specific (and often costly) health needs to prescreened donors who can quickly mobilize funds. For example, one participant mentioned that Heart Fund Pakistan is working on developing a mobile platform to link donors to patients who come into emergency services and hospitals and cannot afford their care, in order to transfer funds in a short time frame. This participant questioned whether a knowledge exchange platform such as this might facilitate the growth of direct matching services, particularly regarding access by women.
- Defining empowerment: The World Bank definition of empowerment is very capital- and investment-oriented, but individuals such as Patricia Hill Collins, professor of sociology at the University of Maryland, College Park, have proposed a social justice-oriented paradigm of resisting the dominating forces that disempower women. One way that disempowerment is inadvertently promoted is through implementation without “on the ground” input.
- Replicating success: Programs do not always translate to other countries or new settings and at times require extensive adaptation. This includes transferring programs between the commercial, for-profit space and the public sector as noted by one of the participants.

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## 3

# Strengthening Health Systems

### Key Messages

At the same time that there are acute shortages, these countries also have high unemployment. Clearly there is a mismatch between the health care problem and the production, supply, and employment of health workers.

—Akiko Maeda

Many of [these innovators] have tried to flip the health challenges on its head, [and see these as] really fantastic opportunities for entrepreneurs to think about disruptive technologies, new models of care, and especially novel workforce development programs.

—Krishna Udayakumar

We have a fixation with the old notion of counting heads. . . . How many patients does a nurse care for in a public setting, in an NGO [nongovernmental organization] setting, in a corporate setting? They vary. So our fixation with counting heads, graduates, licenses, is not very useful. We have to think about other ways of measuring productivity.

—Oscar Picazo

A strong and functional health system is a key element in meeting standards of quality and delivery of care. Health systems differ greatly around the world in terms of organization, principles, culture, funding, staffing, patient population, and many other indicators. Workshop participants discussed some differences and similarities between health systems. They also explored opportunities to increase participation, diffuse innovation, and enhance investment.

### TRENDS IN THE HEALTH WORKFORCE<sup>1</sup>

Akiko Maeda described a number of economic, demographic, and health workforce drivers that are shaping the role of nurses and midwives. Currently, there is a severe and acute shortage of health workers, as the World Health Organization (WHO) and others have noted (WHO and GHWA, 2013). This is true not only for low-income countries, with growing populations and lack of capacity, but also for high-income countries, whose aging population demands additional services while the labor force shrinks. Middle-income countries also face this shortage because of increasing demands from a growing middle class, even while inequities remain.

But at the same time, many countries face high unemployment even while there is a demand for these skilled workers. Maeda remarked that the combination of these two issues indicates there is a substantial gap in economic resources and capacities as countries continue with the same service delivery models and technologies. She postulated that an additional gap in understanding of the problem itself exists, which poses challenges for developing solutions.

In a report highlighting 11 country case studies, Maeda and her colleagues observed that in order to reach a WHO-established minimal threshold for health care worker density, several countries would require huge scale-up and investment (Maeda et al., 2014). This threshold, set at 22.8 workers per 10,000 population, is intended to serve as a proxy for universal health coverage. In some countries they assessed, such as France and Japan, that coverage is met, while in Ethiopia, a 1,000 percent increase would be required. However, Maeda also pointed out that while Thailand is below the threshold (at 17.4 workers per 10,000), it is currently achieving universal health coverage (see Table 3-1). She suggested that the current metric is not necessarily the most useful one because it does not account for different service delivery models and how they are deployed throughout the world.

There is a mismatch, Maeda proposed, between health care workforce shortages and development of health care workers. By examining trends in health professional development, she stated that research indicates increas-

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<sup>1</sup> This section summarizes information presented by Akiko Maeda, The World Bank.

TABLE 3-1 Health Workforce Estimates<sup>a</sup>

Country	Density of skilled health professionals (doctors, nurses, and midwives) per 10,000 population, circa 2010	Percentage change in workforce required to reach 22.8 per 10,000 threshold by 2035
Group 1		
Bangladesh	5.7	404
Ethiopia	2.7	1,354
Group 2		
Ghana	13.6	221
Indonesia	16.1	78
Peru	22.2	33
Vietnam	22.3	19 <sup>b</sup>
Group 3		
Brazil	81.4	0
Thailand	17.4	32
Turkey	41.1	0
Group 4		
France	126.6	0
Japan	63.3	0

NOTE: According to Maeda et al., “Group 1 countries are still setting the national policy agenda for moving toward universal health coverage (UHC); Group 2 countries have made substantial progress toward UHC but still face significant gaps in coverage; those in Group 3 have recently achieved many UHC policy goals but face new challenges in deepening and sustaining coverage; and Group 4 countries have mature health systems with UHC but are still having to adjust national policies to meet changing demographic and economic conditions” (p. 1).

<sup>a</sup> Health workforce density of 22.8 skilled health professionals per 10,000 population is the lower level recommended by the World Health Organization to achieve relatively high coverage for essential health interventions in countries most in need (WHO, 2006).

<sup>b</sup> Maeda et al., 2014, authors’ calculation.

SOURCE: Maeda et al., 2014.

ing specialization in the health field across high-, middle-, and low-income countries. Owing to technological changes, there is a demand for higher-skilled workers, which requires additional schooling, which then necessitates higher returns for that educational investment (Schumacher, 2002). There are additional market forces, including private for-profit training opportunities and globalization of labor—but these pose a challenge for achieving universal health coverage because they draw resources from primary care and underprivileged populations. It is not enough to train more

doctors and nurses if they are not filling the right gaps, said Maeda. She raised the question of finding ways to continue to move the market while orienting health sector employment toward more socially and publicly necessary domains.

In response to this shortage in the primary care workforce, many countries have expanded midlevel and other categories of health workers. Such workers include physician assistants in the United States, licensed practical nurses in Japan, and health extension workers in Ethiopia. This cadre of workers includes secondary graduates who take on the primary health care role. They require shorter training times and have lower wage expectations, so are considered less expensive. With the deployment of this category of worker, access to health care has expanded, but questions still remain regarding quality of care, regulation, and organizational management. However, even as the number of primary care doctors and nurses has decreased, access to health care is improving in a number of countries, reflecting the impact of these additional midlevel workers. Maeda shared the example of Ethiopia Ministry of Health's Health Extension Program, which mobilized an additional 30,000 health extension workers to improve basic primary care access.<sup>2</sup>

The emergence of these midlevel health care workers has had consequences beyond the health care system. In the case of Ethiopia, women make up a large number of these workers, and their entry into the workforce has bolstered their empowerment. Some of them are becoming community activists and leaders because they have education, knowledge, and status. Since the program is only 6 years old, Maeda asserted that it will be important to track the effects on the community of these changes in health delivery and the increased participation of women.

Other effects include the changing composition of the health workforce, which has resulted in resistance from established health professionals such as physicians and nurses. What are the roles of these professionals in these new delivery models? How can these different levels support each other in finding appropriate niches? In particular, Maeda wondered whether these changes in workforce composition and country demographics are also providing opportunities for nurses to play new roles, particularly in community-based care.

She mentioned a few challenges in moving forward with new health care service delivery models, including the lack of data. The existing data are limited and do not reflect the diversity of education, training, and roles played by auxiliary or midlevel health care workers. Another challenge is understanding health worker preferences and behaviors, particularly in

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<sup>2</sup> For more information about the Ethiopia Ministry of Health's Health Extension Program, visit <http://www.moh.gov.et/hsep> (accessed February 4, 2015).

terms of how they respond to new incentives or regulations. She said there is a lack of data about how a health care worker will respond, and behavioral economics could be used to understand health care responses if this data were collected. Finally, she raised the possibility of holding a dialogue around wages and provider payment reforms, as well as other nonmonetary incentives.

### SCALING INNOVATION IN HEALTH SYSTEMS<sup>3</sup>

Krishna Udayakumar described a framework he and his colleagues use for country-level analysis that identifies leading innovators addressing health challenges such as noncommunicable diseases or changing demographics. Udayakumar and colleagues examine organizations that have employed disruptive technologies, new models of care, or workforce development programs to lead improvements in cost, quality, or access to care. He shared a few examples of these innovations.

One Family Health is a business model in sub-Saharan Africa for female nurses who buy into a franchise with a standardized set of training, supply chain, and backstop functions. The model empowers women so they can become entrepreneurs and manage their own clinics.

Lifespring Hospital consists of 15 maternity and childcare facilities in Uttar Pradesh, India. They use principles of the business model Lean Six Sigma, relying on midwives as care providers to provide routine delivery.

Medicall Home is a subscription-based service supported by Mexitel, a national cellphone company. Subscribers have 24-hour access to a call center staffed by nurses and a few physicians. More than 60 percent of inquiries are resolved by phone only, and the others are referred to a network of discount service providers as needed.

Grand-Aides is based in the United States and involves training lay-people to provide community-based primary care and transition from acute to home care under supervision.

#### Keys to Success

Udayakumar explained that these social enterprises have potential for effecting change in health care delivery and access, as well as empowering women through greater employment participation. He sought to determine what made these programs successful and what could be applied elsewhere. He noted a few “secrets of success.” First, patients should be at the center of providing and improving health and health care, and their consumer

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<sup>3</sup> This section summarizes information presented by Krishna Udayakumar, International Partnership for Innovative Healthcare Delivery (IPIHD).

patterns and behavior should be tracked. Second, while technology is driving increasing specialization, another trend is the opposite. Mass uptake of technology, like the use of mobile phones, empowers task shifting by allowing workers to provide higher level of services with support. Third, there is potential in transforming the workforce by focusing on competency versus traditional assumptions of the roles of health care professionals. Fourth, reducing variability of care and increasing standardization almost always leads to improved consistency and quality. Lastly, health care tends to be a capital- and resource-intensive sector, so costs can be averted by leveraging existing assets in innovative ways, such as the use of mobile networks as platforms.

### Identifying the Gaps

Udayakumar noted that there are also gaps in scaling or replicating these models. First, many of these entrepreneurs are working in isolation from each other, so they cannot readily access one another's experience. This includes capturing data that can be used for scaling up innovative models in different settings. Second, there is a lack of organizational capability, or business skills, so how can such capacity be built within organizations? Third, a means of creating a more efficient marketplace that permits funding to flow to the right organization at the right time should be explored—in particular, the means by which small and medium enterprises can access the much larger pool of public funds. And finally, entrepreneurs are constrained by their environments, including policy and regulatory restrictions and entrenched health systems.

### Responding to a Need

In response to these issues, Udayakumar and his colleagues created a nonprofit organization, International Partnership for Innovative Healthcare Delivery (IPIHD), to develop a platform that could better link entrepreneurs so they can share knowledge, share best practices, and build capacity (see Figure 3-1). He also emphasized the importance of local context; while sharing knowledge and best practices around the world is useful, replication requires careful consideration of the specific context. IPIHD is currently working to prioritize the regions of East Africa and India, where a clustering and an ecosystem of innovation have developed.

Within the larger learning network, Udayakumar highlighted a few working groups with more specific foci. These working groups include several of these innovative programs as well as foundations, corporations, and government agencies who work within the area of focus. He named three: the diabetes working group, the reverse innovation working group, and the

Social Entrepreneurship Accelerator at Duke (SEAD). The diabetes working group brings together about ten innovative organizations that are already deploying technologies and new business models for diabetes diagnosis management and treatment. These organizations, including technology companies or other large organizations such as foundations, are interested in how they can scale diabetes solutions. The second group looks at how to better diffuse across boundaries the good work that is happening on the ground, especially in terms of replication or adaptation of successful models in low- and middle-income countries to high-income countries. The third, SEAD, is a partnership with the Duke business school and the Duke Center for the Advancement of Social Entrepreneurship, where for ten years they have studied how best to scale the impact of social enterprises to determine what a prominent research-based university may contribute to develop a global health accelerator.<sup>4</sup>

IPIHD is still relatively young, but there is anecdotal evidence of its beneficial effects. Some of the previously mentioned organizations have expanded or have been replicated, and there have been some improvements in providing funding. IPIHD is also implementing another model for scaling up—strategic collaboration. This goes beyond funding or venture capital by leveraging the reach and capacity of large companies. He gave the example of Medtronic, which is using the health platform of ClickMedix as a screening tool for hearing loss among children in India.

Udayakumar closed with further details of the example of One Family Health in Rwanda. Lessons learned in implementing a similar model in Kenya, in which the franchise reached its limit at 80 clinics because of the lack of integration in the public health care sector, informed the creation of a public–private partnership in Rwanda. Working directly with the Ministry of Health, a hub-and-spoke model was created in which the public primary health center was the hub and One Family Health created “spokes” that referred less complex needs to smaller clinics embedded in the community. Because the main clinic was public, the partnership had access to the public financing and subsidy mechanism. It was also able to create a microfinance feature for each franchisee. Additionally, there was seed funding from GlaxoSmithKline to build the initial infrastructure, but once the number of franchises reaches 300, the system will be self-sustaining on franchise fees. Should the model succeed, Udayakumar observed, there could be valuable lessons for those in other countries building similar models. Such systematization of innovation could shape the future of health care delivery.

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<sup>4</sup> A global health accelerator is a mechanism to capitalize on innovations and expertise in developing countries in order to provide a suite of support services (R4D, n.d.).



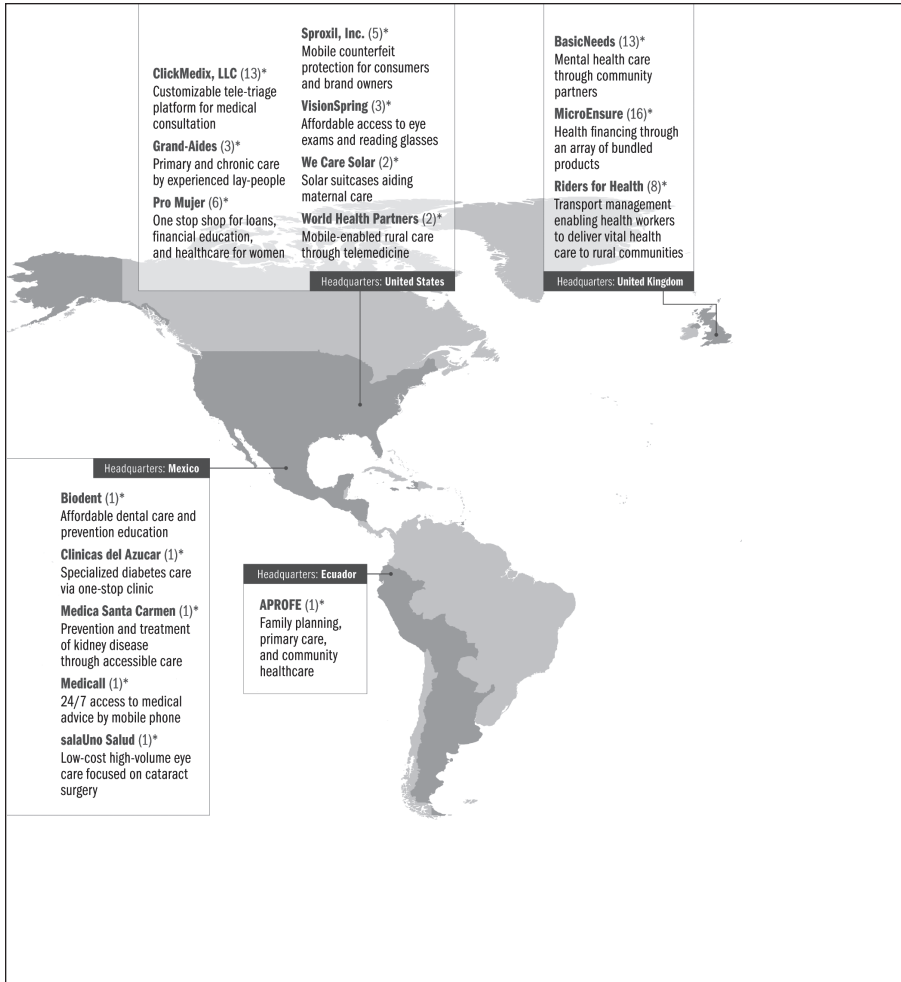
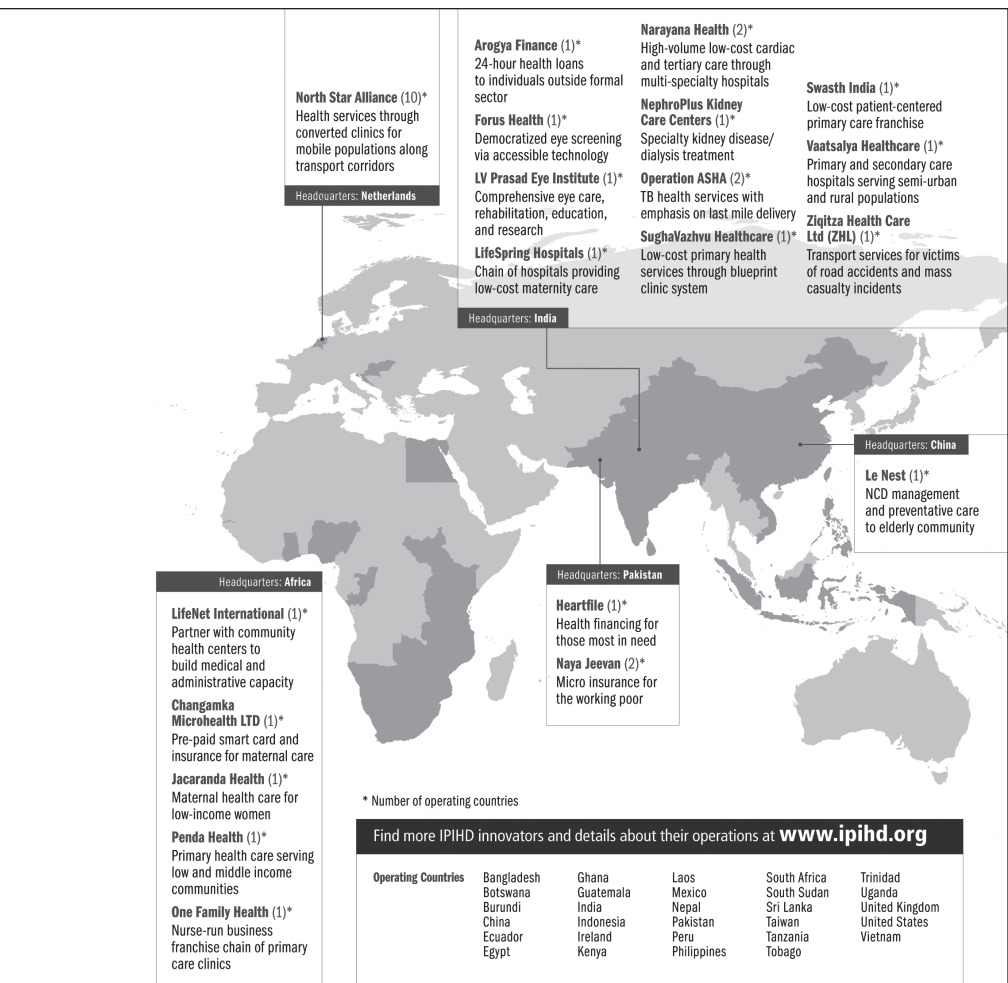


FIGURE 3-1 2014 IPIHD Innovator Network.  
 SOURCES: IPIHD, 2014, and Udayakumar, 2014.



### TOWARD A NEW PARADIGM<sup>5</sup>

In his remarks, Picazo questioned why there is such low emphasis on understanding how technology impacts work, productivity, and training of health professionals. The examples he referred to include eHealth for practices supported by electronic processes and virtual communication as well as electronic health records for data collection, billing, and quality improvement efforts. He considered the impact swipe cards could have on the tasks of nurses and midwives who spend considerable time filling out forms. A cost-savings trend in the United States, he said, is to have administrative tasks such as claims processing outsourced to groups in Eastern Europe, India, South Africa, Turkey, and the Philippines. All of these advances in technology and globalization affect how health workers are or should be trained in the United States and in emerging economies like the Philippines, where there are 10 different electronic medical records currently operating. Along with rapidly changing health care delivery systems, Picazo pointed out that medical tourism is a growing industry. There are now large numbers of patients and consumers crossing national and international borders for health and health care treatments. This has implications for facility planning, considering that it is cheaper to fly a patient to Manila rather than establish a specialty hospital on the Philippine island of Mindanao.

He also noted that the mobility of both patients and health care workers coupled with mobile technologies means that workers and knowledge are more nimble. For example, the use of teleradiology, in which images from remote locations can be digitized and sent to specialists and diagnosticians in central locations, means radiologists and other specialists do not need to be staffed at all hospitals. These changes in the paradigm of health workforce development are also reflected in the need to develop more collaborative, team-based approaches. Not only do tasks shift among different workers and levels in real time, but depending on the setting and outcomes, the composition of these teams is constantly changing.

Picazo also highlighted the intersection of health care and social care; cash transfers are often used to pay for health care services, but traditionally fall under social welfare schemes. This requires greater coordination not only between these two systems at the country level, but also with partners such as nongovernmental organizations and donors. At this intersection is also the flexible role of nurses. They are not always caregivers, Picazo asserted; they can also serve as social workers, among other roles. At the same time, the old model of “counting heads,” as in, how many patients does a health professional care for in a certain setting, is outdated,

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<sup>5</sup> This section summarizes information presented by Oscar Picazo, Philippine Institute for Development Studies.

and the focus should be on finding other ways to measure productivity. Picazo closed by stating, among all of these elements, that care is bound to culture. Regional or global standards are important, but the influence of culture cannot be separated.

## PERSPECTIVES ON STRENGTHENING HEALTH SYSTEMS

In the discussion following the presentations, participants and speakers further explored some of the seminal themes that emerged and raised additional themes. Below are some of the perspectives discussed by individual participants during the discussion<sup>6</sup>:

- Innovations often best diffuse laterally and not from the top down, inviting room for discussion about better means of dissemination and implementation as well as the use of online platforms for training on program design.
- Investing in tangible infrastructure, such as hospitals, can be more attractive to a government because the return on investment is higher, particularly among a growing middle class. However, reaching to vulnerable and low-income populations is more of a challenge, particularly in the investment space.
- One participant emphasized that seeding investments and sharing innovations should have the aim of scaling up and replicating successful programs, not continuously implementing and testing pilot programs.

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<sup>6</sup> Statements, recommendations, and opinions expressed are those of individual presenters and participants and are not necessarily endorsed or verified by the Institute of Medicine. They should not be construed as reflecting any group consensus.

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## Part II



## 4

# Nursing and Midwifery Education and Enterprise

### Key Messages

In most of the world, nursing and midwifery are at a postsecondary educational level, which in itself is a barrier for many girls going into a profession because girls, especially in low- and middle-income countries, [often] drop out before completion of secondary education for a variety of reasons.

—Mary Barger

Strengthening women’s own capabilities to care for themselves and their families is empowerment of more than one person. It is not just the midwife who knows how to do this, but also the woman, and her family, and her community, and ultimately also her child.

—Petra ten Hoope-Bender

Younger nurses are more business- and leadership-oriented; if given the proper support, they could be transformational in the health system.

—Barbara Parfitt



## SETTING THE STAGE<sup>1</sup>

Mary Barger pointed out that midwifery and nursing are two separate disciplines, even though they are often joined together in the United States. In most of the world, the two are at a postsecondary educational level; this can be a barrier for many young women who do not complete secondary education. However, if these young people can be retained through secondary school, then the fields of nursing and midwifery can be areas for further education. She gave the example of a nonprofit organization in Malawi that assists young women to purchase school uniforms, books, and other supplies, and then provides stipends to continue in nursing and midwifery providing that they work at a government facility for roughly 2 years after graduating.

Barger stated that there are international competencies for midwifery, which were developed by the International Confederation of Midwives (ICM). Additionally, she said, there is some question as to whether auxiliary midwives meet those competencies. There are also questions around the number of months of education, short programs versus longer ones, and clinical teaching structures. In some countries, the results of entrance exams determine which health professional track students will be placed. However, health professionals often take basic courses together, and Barger stated this can cause friction if students in “lower” tracks outperform those in “higher” tracks in the same course. Also, the accreditation process for schools and certification for specialty skills can vary, and curricula can sometimes be outdated.

The context of care for nurses and midwives is also diverse, ranging from the standard hospital settings to clinics and community-based care. Barger remarked that in refugee situations, nurses and midwives are frequently organizing the services, often engaging in innovative public health approaches. Nurses and midwives often find themselves playing the role of supervisor, particularly to community health workers, regardless of whether they have received the necessary leadership skills training.

## STATE OF THE WORLD’S MIDWIFERY<sup>2</sup>

There are a number of perspectives on midwifery, according to Petra ten Hoop-Bender, and a recent *Lancet* series provides an independent space to share and analyze those perspectives. It defines midwifery as:

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<sup>1</sup> This section summarizes information presented by Mary Barger, University of San Diego.

<sup>2</sup> This section summarizes information presented by Petra ten Hoop-Bender, ICS Integrare (Instituto de Cooperación Social Integrare).

Skilled, knowledgeable, and compassionate care for childbearing women, newborn infants, and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum, and the early weeks of life. Core characteristics include optimizing normal biological, psychological, social, and cultural processes of reproduction and early life; timely prevention and management of complications; consultation with and referral to other services; respecting women's individual circumstances and views; and working in partnership with women to strengthen women's own capabilities to care for themselves and their families. (Renfrew et al., 2014, p. 1130)

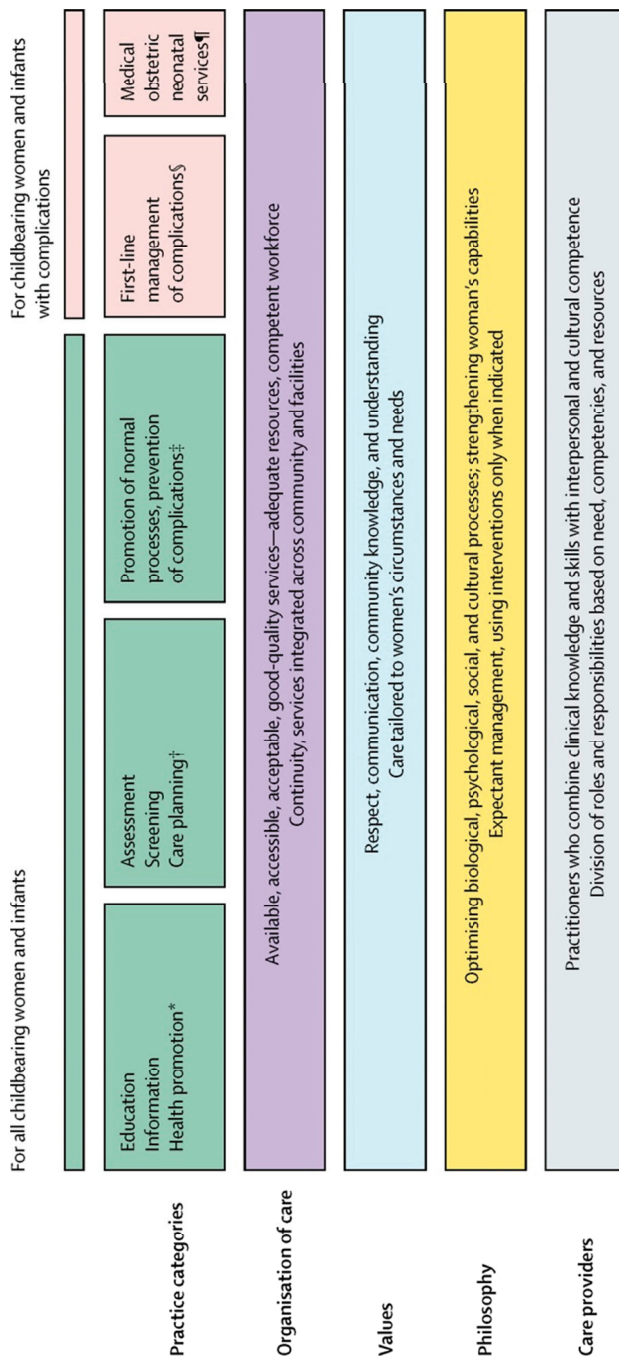
Ten Hoop-Bender highlighted the last section of the definition, which states that a core responsibility of midwives is to strengthen a woman's own capability to care for herself and her family. Because of this, investment in health promotion strengthens not only the midwife, but also the woman, her family, her child, and her community.

The *Lancet* series illustrated a number of important elements (see Figure 4-1). Health care, ten Hoop-Bender noted, should be "organized, available, accessible, acceptable, [and] good quality." Values include respectful and tailored care and community knowledge, while the philosophy of care involves optimizing mental, physical, social, and cultural processes. Ten Hoop-Bender expanded on the latter; maternal and newborn care should be grounded in pregnancy and birth as a normal, not necessarily medical, process that is healthy for both mother and baby, and more realistic for "close-to-client" care provision.

On a related front, ten Hoop-Bender also shared the *State of the World's Midwifery Report 2014*, which examined 73 countries over a 15-year projection (UNFPA et al., 2014). It established a baseline on workforce, education, interventions, and productivity, and then costed scenarios with assumptions of reasonable improvement in these areas. For example, it considered lower staffing attrition (among all health care staff, not just midwives), more standardized education, and better family planning. Among some of the outcome measures included are an estimated 16 percent return on investment in midwives when regarding lives saved and caesarean sections prevented, as well as recognition that when midwives are trained to international standards, they can provide 87 percent of the essential interventions necessary for women and newborns.

Ten Hoop-Bender shared some examples of innovations that can help promote a greater global understanding of the role midwives can play in a more effective health system:

- Jacaranda Health is a social venture combining business and clinical innovations that targets women living in Nairobi, Kenya's peri-urban areas. It provides high-quality, friendly, and affordable



**FIGURE 4-1** The framework for quality maternal and newborn care: maternal and newborn health components of a health system needed by childbearing women and newborn infants.

SOURCE: Renfrew et al., 2014. Reprinted with permission from Elsevier (*Lancet*, 2014, 384(9948):1129-1145).

maternal care through a set of self-sustaining and scalable clinics. The program has a dual focus of addressing the needs of the female patients it serves, as well as improving the standard of care.

- Manoshi is a program focused on migrant populations living in informal urban settlements in Bangladesh, where birth usually occurs in homes of 10–15 inhabitants, and there is no privacy. Clean birthing centers were established, and community health workers reached out to the population regarding prenatal and antenatal care. Additionally, they developed a referral service where they could transport women to hospitals and assist them through administration at the hospital and into the delivery room, cutting out several of the serious delays that can cost women their life.
- The Afghanistan community midwife program selects women in the community to be trained as midwives and then return to the community to work. It has led to the creation of the very visible Afghanistan Midwife Association in 2006, with 3,000 members.

#### ANNOTATIONS TO FIGURE 4-1

\* Examples of education, information, and health promotion include maternal nutrition, family planning, and breastfeeding promotion.

† Examples of assessment, screening, and care planning include planning for transfer to other services as needed, screening for sexually transmitted diseases, diabetes, HIV, pre-eclampsia, mental health problems, and assessment of labor progress.

‡ Examples of promoting normal processes and preventing complications include prevention of mother-to-child transmission of HIV, encouraging mobility in labor, clinical, emotional, and psychosocial care during uncomplicated labor and birth, immediate care of the newborn baby, skin-to-skin contact, and support for breastfeeding.

§ Examples of first-line management of complications include treatment of infections in pregnancy, anti-D administration in pregnancy for rhesus-negative women, external cephalic version for breech presentation, and basic and emergency obstetric and newborn baby care (WHO 2009 monitoring emergency care), such as management of pre-eclampsia, post-partum iron deficiency anemia, and post-partum hemorrhage.

¶ Examples of management of serious complications include elective and emergency caesarean section, blood transfusion, care for women with multiple births and medical complications such as HIV and diabetes, and services for preterm, small for gestational age, and sick neonates.

**TABLE 4-1** Hypothetical Model of Inadequate Access to Antenatal Care in Low and Middle Income Countries

Program Design Standard antenatal programs (WHO, 2002)		Women's Views and Experiences Findings from meta-synthesis (Finlayson and Downe, 2013)	
Theories that underpin antenatal care programs	Pregnancy is potentially risky for mother and baby	Beliefs and attitudes	Pregnancy is a healthy physical state
	Pregnancy is a positive social state that will, in general, be welcomed by the family and community		Pregnancy can be socially risky. It can be subject to malign magical forces from jealous relatives and community members
	Women and families have enough resources to make rational economic choices to access care		A choice to access care might mean a risk to survival, either due to resultant lack of food in the future, or because of the difficulties and dangers associated with travel to health care facilities
Principles of care delivery	Antenatal care is affordable	Experience of care delivery	Antenatal care is subject to unexpected costs levied at the point of need
	Staff attitude is not relevant and/or is generally positive		Staff attitude is highly relevant, and can be discriminatory, neglectful, or even abusive
	All the resources needed for the level of care on offer are present		Resources are often not available, and transfer is then necessary to the next level of care

NOTE: This table represents one section of the original table. The complete version of this table can be found in Finlayson and Downe, 2013.

SOURCE: Finlayson and Downe, 2013.

The training of these midwives and the establishment of standards of care contributed to a more than 50 percent reduction in maternal mortality. Additionally, the midwives gained standing in their communities and were consulted on women's and family issues.

- The Community-Based Midwifery Diploma Program at BRAC University in Bangladesh is a hub-and-spoke model of education in which faculty and curricula are developed at the “hub” and students are locally selected at the “spokes.” An assessment of the program noted that the investment yielded major returns in fewer obstetric complications and surgeries as well as more infant and maternal lives saved.

Ten Hoop-Bender distilled some lessons from these programs, culminating in the concept of midwife-led units for birthing and early childcare. This approach keeps midwives close to the community, with outreach through community health workers. A Cochrane review showed that such an approach could lead to higher maternal satisfaction and better maternal and neonatal outcomes (Sandall et al., 2013). She concluded, cautiously, that such approaches should be implemented incrementally with transition models and country-level health system internalization. She also reiterated the need to make programs consumer-focused by embedding consumers into the initial design. She shared the details of some research that shows there can be a disconnection between the perspectives of program designers and the end-users, using the example of antenatal care centers (see Table 4-1).

Following the presentation, speakers and participants raised additional questions about enhancing nursing and midwifery education and impact:

- What is the informal impact of empowering nurses and midwives on their families and communities, and how is that impact measured? Is there a cost savings for informal services nurses and midwives might provide outside of health care settings?
- When women are not traditionally part of the leadership in a community, are there ways to ensure they are heard and respected as technical experts? One participant described a program in Egypt in which social change agents are identified to support the nurse or midwife's efforts.

### WOMEN'S EMPOWERMENT THROUGH EDUCATION USING A SOCIAL BUSINESS MODEL<sup>3</sup>

Barbara Parfitt stated that women are disadvantaged in countries in South and Central Asia, which reduces their employment opportunities and has an effect on nursing. Nursing is a low-status profession, she explained, with low salaries, poor working conditions, and little investment. It is primarily controlled by doctors who make all of the decisions around what nurses do, and in some cases, inhibit the development of nursing. The private sector is variable in standards, innovations, and quality of care, while the government hospitals are overused, poorly resourced, undersupported, and badly managed. Nurses are considered “extra hands” for doctors and are not given much agency. There are few nurses in community health centers, which consist mainly of paramedics and community health workers.

At the same time, the environment is changing rapidly. Prestige is given to educational qualifications, which can help improve the status of nursing and of women. Younger nurses are more business and leadership oriented; if given the proper support, they could be transformational in the health system. The government is issuing new policies toward the goal of improving nursing care, but sometimes the top-down process is slow and difficult to implement.

Parfitt described another approach to improving nursing care through the private sector. She and her colleagues have helped develop a private nursing college, the Grameen Caledonian College of Nursing in Dhaka, Bangladesh, with a 3-year joint diploma in nursing and midwifery in collaboration with the government; it has government approval and uses the government curriculum. The faculty at the college in Bangladesh were mentored and trained by faculty at Glasgow Caledonian University, resulting in a much higher standard of nurse educator. The students not only learn the curriculum in a high-quality educational environment, but are also empowered with entrepreneurial, leadership, and technical skills to become change agents in the health system. The college also continues to mentor and support students after graduation. She explained that the evaluation of the program will focus on four key questions:

1. Is the program improving the poverty levels of the students and their families?
2. Is it improving their health and families' health?
3. Are young women being developed as skilled nurses at the highest evidence-based international standards?
4. Are the students demonstrating leadership skills and empowerment?

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<sup>3</sup> This section summarizes information presented by Barbara Parfitt, Glasgow Caledonian University.

Parfitt also emphasized that the program is not a charity, but a social business that pays at market rates and does not have shareholders. Thus, it required funds for start-up in the form of loans for both the business and the students' tuition; this means that students would pay fees, and at 500 students, the college would be self-sustainable. Once the success of the program has been demonstrated, she and her colleagues plan to scale up to 10 more colleges in Bangladesh.

When asked how the program ensures that graduates remain in their communities working, Parfitt underscored that she did not believe empowerment programs should restrict opportunities. She felt that if students want to emigrate, it should be their decision. She also noted that nurses who emigrate to work in other countries often return to their home countries. In interviews with students applying to the program, she discovered that many of the students have a strong tie to their communities and prefer to remain and work toward their improvement.

In addressing tension that arises within the traditional doctor community in response to this changing role of nurses, Parfitt explained that she invites doctors to join workshops with the nurses so they can see the program in action. She also pointed out that the program requires cooperation with the hospitals so they can place the nurses in those settings for their clinical training; as a result, the program leaders meet directly with doctors to help them see the value of their program and to ask for their help to place their nurses.

In closing, Parfitt discussed strategies for integrating nursing care into community health that included training and supervising community health workers. Some of the nurses spend a few weeks in community-based primary care for their clinical rotations. The trainees partner with groups developing "clinics in a box" (also known as "shipping container clinics") that provide basic health services to people located in rural villages. Parfitt explained that she plans to install a community health clinic staffed by students at Grameen Caledonian College in Dhaka to serve the nearby population living in informal urban settlements. This will provide nursing students more immediate experience in community health that will help develop their clinical skills in hospital settings.

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## 5

# Country Perspectives

### Key Messages

It is important to have continuity of care not only in practice but also in location.

—Amal Abu Awad

If you go to a primary health center that is staffed with community health workers and one that has a nurse or midwife, usually you can see the difference in the quality of care. So now the government is trying to get more nurses and more midwives into that system.

—Emilia Iwu

From the beginning, we have admitted women [of] lower-middle and lower economic status to training schools, and they have become nurses; they have become sustainers of families and sustainers of communities.

—Julie Fairman

The local context plays a strong role in the development of nursing and midwifery enterprise, despite global standards of education, training, and care provision. Speakers discussed the architecture, priority setting, and future development of nursing and midwifery education and programs in

Palestine, Nigeria, and the United States, highlighting both unique and communal challenges.

### SYSTEMATIC INITIATIVES TO EMPOWER NURSES AND MIDWIVES AND IMPROVE HEALTH SERVICES IN PALESTINE<sup>1</sup>

There are many definitions of empowerment; Amal Abu Awad shared one from UN Women, which lists seven principles. These principles, she noted, align with the programs she runs. The principles are

1. Leadership promotes gender equality;
2. Equal opportunity, inclusion, and nondiscrimination;
3. Health, safety, and freedom from violence;
4. Education and training;
5. Enterprise development, supply chain, and marketing practices;
6. Community leadership and engagement; and
7. Transparency, measuring, and reporting (UN Women, n.d.).

Awad explained that Palestine has two main regions: West Bank and Gaza. In the West Bank there are 6 midwifery programs and 15 nursing programs, while in Gaza there are 2 midwifery programs and 4 nursing programs. In the West Bank, two of the midwifery programs and seven of the nursing programs are 2-year programs, which they are working on phasing out because they do not meet the desired quality of care. Her college, Ibn Sina College in the West Bank, is the only governmental university college providing bachelor-level degrees in nursing and in midwifery. She praised the quality of the education, but also remarked that because of government subsidies, the tuition is low or, in the case of midwifery, free.

The national strategy to improve the quality of nurses and midwives is reflected in the curricula of the educational programs. Principles of the programs include

- Commitment to using evidence-based practices, which includes using the most recent textbooks and designing courses around internationally recognized competencies;
- Integration of new practice protocols within the curriculum, which includes bringing students and service providers closer together;
- Curriculum update and regular review by the minister for health education every 5 years; and

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<sup>1</sup> This section summarizes information presented by Amal Abu Awad, Palestinian Ministry of Health.

- Quality assurance for training experience, including low student–teacher ratios, early patient contact, and clinical training.

She described that a special course was required for training about gender-based violence and domestic violence; lecturers were specially trained, and there were specific credits for the course and for family protection interventions. Awareness increased among students, and students reflected on their personal and family experiences. To create other specialty courses at the college, course designers from specialties such as medicine and radiology were trained so that they could design courses for their respective field. Ibn Sina College also hopes to connect with universities abroad in order to bring additional specialty courses to the college, such as courses on oncology or burns. By establishing these connections, the college is working to improve the health system and to ensure quality of care. She also said that due to improvements in internet access, the hospitals' online resources have expanded; for example, hospitals now offer virtual training courses for both students and care providers.

Awad stated that the health ministry is also interested in increasing the capacity and quality of the midwifery programs, with campaigns to attract new students. The focus is to foster independence as well as to promote the use of natural birthing processes. The curriculum has been updated, and has the midwives' job descriptions, which are now in accordance with the advanced competencies of the International Confederation of Midwives. This includes incorporating additional advanced competencies such as IUD (intrauterine device) insertion and removal and episiotomy cut and repair. It also includes a model for continuity of care supported by the Norwegian Aid Committee (NORWAC), which links and supports the midwifery practice in both hospitals and communities. Awad closed by noting areas of continued support and progress:

- Faculty development,
- Staff development,
- Extracurricular activities,
- Students involvement,
- Professional regulation and organization, and
- Upgrading of existing diploma holders to the bachelor of science level.

## PERSPECTIVES FROM NIGERIA<sup>2</sup>

There are an estimated 124,629 nurses and 88,796 midwives in Nigeria as determined by the Nigerian National Strategic Health Development Plan, stated Emilia Iwu, but this data is in the process of being updated. The Nursing and Midwifery Council of Nigeria, she said, continuously seeks to improve nursing practice and professionalism, but further collaborative work is needed to better translate effective nursing programs and strategies from other countries to the Nigerian context. One challenge, she noted, is the public perception and media portrayal of nurses because “not everybody in a white uniform is a nurse” (especially in nonpublic facilities). Unfortunately, auxiliary nurses without any formal nursing education often present themselves to the public as “nurses,” she explained.

Iwu described how nursing education in Nigeria occurs at different levels. Diploma nursing and diploma midwifery are each 3-year programs. There are also post-basic specialty certificate programs, such as pediatric; ear, nose, and throat; occupational; orthopedic; peri-operative; and intensive care nursing. The baccalaureate nursing degree is a 5-year program that usually contains a midwifery component and at times offers elements of public health education. Twenty universities offer baccalaureate degree, three offer masters, and two offer doctorates in nursing. Registered nurses and midwives work at all levels of health facilities, she said, but those with graduate degrees work mostly in academic settings.

However, she raised a few challenges in nursing and midwifery education, including faculty shortage and faculty academic progression and retention difficulties. These, coupled with lack of educational infrastructure availability or upgrade challenges, lead to accreditation difficulties for many of the schools. Lack of faculty retention also affects student–teacher ratios, which is supposed to be 1-to-10 in the diploma programs. Iwu stated that there is a dire need for faculty career and education progression strategies, as well as a need to develop a faculty pipeline for future educators especially with anticipated retirement of the baby boomer generation from the system. The Nursing and Midwifery Council acknowledges the gap in the salaries of nurse educators when compared to their counterparts in practice settings. Therefore, they are exploring ways to equalize and create incentives to make the salary equitable. These strategies include provision of opportunities to further education, search for collaborations for scholarship, tuition support, and endowment funds. Additionally, she said, there is limited capacity for existing baccalaureate programs to move diploma nurses through the universities. Iwu described a desire in Nigeria for increased south–south

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<sup>2</sup> This section summarizes information presented by Emilia Iwu, PEPFAR (The U.S. President’s Emergency Plan for AIDS Relief) in Abuja, Nigeria.

and north–south collaborations to enhance the capacity of university-based programs through twinning relationships and online learning opportunities to resolve these nursing education workforce challenges.

Both the nursing and midwifery programs are postsecondary education, which Iwu believes is disadvantageous for socially vulnerable girls and young women who drop out of school or who are married off before they finish secondary education. There are some remedial programs especially in northern Nigeria that assist such girls and young women to attain the requisite educational preparation and qualification for admission to nursing, midwifery, and community health practitioner schools. If they are able to go through the remedial programs and pass, they are admitted to these programs.

Although nurses and midwives can be found in every community in Nigeria, said Iwu, historically the majority of them work in urban and semi-urban hospitals as opposed to community health centers. To address this maldistribution and to increase the number of skilled obstetric care providers, the government implemented the Midwives Service Scheme in 2009 in an effort to reduce maternal/child mortality and morbidity in rural areas. This program deploys newly graduated and retired midwives to rural primary health centers often served by community health workers alone. The objective is to augment and improve quality of care provided especially in hard-to-reach communities with limited access to urban or semi-urban health facilities. Iwu remarked that this is very important as inclusion of nurses and midwives in these settings improves quality and provides opportunities for expanded holistic care.

### NURSING AND MIDWIFERY IN THE UNITED STATES<sup>3</sup>

Nursing in the United States has traditionally been a way of upward social and economic mobility, Julie Fairman explained. Working class women have attended nursing schools over the last century and acquired skills needed to care for the health of families and communities. The Institute of Medicine (IOM) in 2010 noted that 80 percent of nurses should have a bachelor of science degree in nursing by 2020 because baccalaureate programs support their students to develop skills and knowledge to provide care in communities and lead community-based models of care (IOM, 2010). However, community colleges and associate degree nursing programs are an important pipeline for lower-income women to gain access to the profession. This has presented a challenge to address both the needs of students and of patients. She also noted that historically, nurses have been

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<sup>3</sup> This section summarizes information presented by Julie Fairman, University of Pennsylvania.

involved in the provision of affordable community-based care, which raises the question of why some of these approaches have not been successfully scaled up.

Two programs she spoke about include the nationwide Nurse–Family Partnership (NFP) in Denver, Colorado, and the Developing Families Center in Washington, DC. The NFP was developed by David Olds, a physician, and Harriet Kitzman, a nurse, in the 1970s. It pairs a nurse, and more recently a community health worker, with a low-income, first-time pregnant woman in her second trimester. The nurse follows the mother for 2 to 3 years and provides skills and knowledge as part of a “toolkit.” The program has been known for its outcomes, such as a 48 percent reduction in neglect and abuse, 59 percent decrease in criminal activity by children before the age of 15, and 67 percent reduction in behavioral and intellectual problems (NFP, 2011). There is also a decrease in partner violence, and increased possibility for mothers to go back to work (NNCC, 2014). While the model is still true to its original intent of nurse visitors, there has been a comparative study examining paraprofessionals and nurses in a randomized controlled trial. On most benchmarks, women and children visited by professional nurses performed at a higher level, although improvements were seen in all groups (Olds et al., 2002). Even so, in some very rural parts of the United States where the health care infrastructure is weak, the NFP is both sustainable and practiced.

The second model Fairman described is the Developing Families Center, created by nurse-midwife Ruth Lubic. The program was initiated based on women’s responses to the medicalization of birth and birthing in hospitals. The Center provides prenatal and postnatal care to women who can choose to give birth at the Center or at local hospitals while supported by the nurse midwives. Lubic began in New York, and in 2000 she opened the Family Health and Birth Center in Washington, DC. After 6 years, the outcomes were favorable among low-income African-American women in the Center, compared to African-American women in Washington, DC:

- Preterm birth: 5 percent, compared to 15.6 percent;
- Low birth weight: 3 percent vs. 14.5 percent;
- C-section rates: 10 percent vs. 31.5 percent (RWJF, 2010).

The center is responsive to the community; Lubic asked the community what they preferred, and an advisory group of women in the community helped develop the programs. She also employed women from the community to serve as lactation consultants, Fairman remarked, illustrating the potential of a bidirectional dialogue around empowerment.

Fairman closed with a brief description of the community health workers movement in the United States, in which women in particular

from the community are trained to work with people with chronic illness. The University of Pennsylvania has such a program (the Penn Center for Community Health Workers), as do some tribal areas. There is also a similar program in Houston called Grand-Aides (mentioned by Krishna Udayakumar in Chapter 3). Fairman cautioned that while these programs have potential for providing greater access to health care and the health care field, the models should not be primarily profit driven to the point of depressed wage rates.

## DISCUSSION

Following the presentations, speakers and participants commented further on the speakers' presentations, particularly regarding the use of community health workers to share tasks. One participant raised the challenge of sustainability that she noticed through her work in Boston; in general, community health workers are intended to create links between health care services and communities. However, some of the workers do eventually seek additional training to "move up the ladder," she said, and this can sometimes have the unintended side effect of removing their close tie to the community.

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## 6

# Innovations and Organizational Strategies to Strengthen Health Systems

### Key Messages

What [small and medium private providers] often need is a benchmark; they need a roadmap on quality, they need investments, and of course they need to have patients that are willing to pay and able to pay.

—Monique Dolfing-Vogelenzang

One of our lessons has been that really focusing on capacity building, and coupling that with program evaluation, can have impact just by building a stronger evidence base so that over time we are not repeating the same mistakes.

—Krishna Udayakumar

You have a few really great innovators that are coming up with fantastic ideas for how to solve these problems, but they remain small scale because the government does not recognize them, because they do not necessarily get capital to invest in them, [and] because they are essentially not in the right enabling environment to become larger.

—Gina Lagomarsino

Women's empowerment has become a pretty central objective across both development and public health agendas; it has long been recognized that there are positive associations going in both directions between having healthy populations and having empowered populations.

—Carleigh Krubiner

Susan Kosman of Aetna Inc. opened this session with a quote from President John Kennedy regarding the space program in the 1960s:

It means a degree of dedication, organization and discipline which have not always characterized our research and development efforts. It means we cannot afford undue work stoppages, inflated costs of material or talent, wasteful interagency rivalries, or a high turnover of key personnel. (Kennedy, 1961)

The “moonshot,” which resulted in the moon landing of Apollo 11 in 1969, required not only commitment and collaboration among stakeholders and the public, but also innovation and a shift in organizational paradigms. Kosman asserted that such an approach would be crucial today in investing in and empowering nursing and midwifery to transform health systems.

### INVESTING IN WOMEN-OWNED HEALTH ENTERPRISES<sup>1</sup>

Monique Dolfig-Vogelenzang spoke about developing alternative approaches to building public goods when state capacity and resources are limited. Her organization focuses on strengthening health systems in sub-Saharan Africa, specifically process, access, and funding. In many countries, there is not enough public funding to cover the cost of patients as well as providers' income. In sub-Saharan Africa, she noted, most countries budget approximately \$20–\$40 per year per patient, compared to approximately \$4,000 per year in Europe (WHO, 2010). With these constraints, the state cannot cover these costs, and the private sector tends to play an increasingly larger role.

Because health care is a service, she explained, there needs to be balance between supply and demand. Strengthening health systems means organizing demand, including insurance, spending, and patients' capacity to pay. On the supply side, there needs to be quality provision of care, which

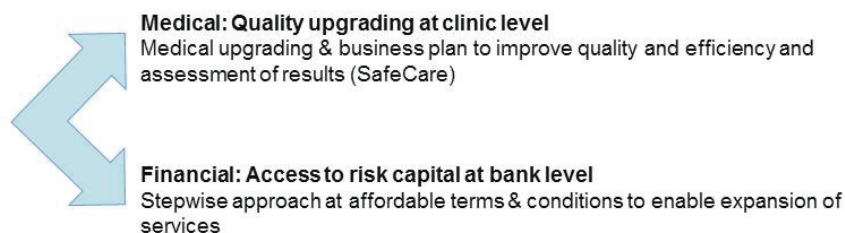
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<sup>1</sup> This section summarizes information presented by Monique Dolfig-Vogelenzang, Medical Credit Fund (MCF).

is often lacking. When it does exist, there are often problems; it is of bad quality, patients have little trust, and there is little willingness to pay.

Ideally, a robust health system would include at least community-based health insurance, or possibly even universal health coverage. However, Dolfig-Vogelenzang pointed out, such a system requires a strong and capable government that can collect taxes; can finance, organize, and regulate the system; and can attract investment. The private sector can fill these gaps in the near term, or partner with the public sector in both the short and long term. The Medical Credit Fund (MCF) was initiated in 2009 by the Dutch company, PharmAccess, to enable primary health care providers in Africa access to investment capital so they can improve the quality of their services and expand their facility. The MCF investment strategy has two risk reduction programs as seen in Figure 6-1 that involve quality measurement and improvement known as SafeCare, and access to risk capital from local banks that are in part guaranteed by MCF.

The SafeCare program aims to develop standards in resource-restricted settings, based on international standards met by good local solutions. Dolfig-Vogelenzang emphasized that it is not an accreditation program, but rather a stepwise improvement system. It is a system that operational-



*The two objectives are interlinked and offered through local partners: Capacity building through health network organizations and local banks*



**FIGURE 6-1** The investment strategy: Two risk reduction programs.  
SOURCE: Dolfig-Vogelenzang, 2014.

izes regulation and enforcement to measure efficiency and gives insight into how the facility is performing—not only regarding profit and loss, but also patient outcomes. It also provides an opportunity for facilities to self-evaluate, and it engenders trust in patients because of a recognizable brand.

Enrolling a clinic in the SafeCare program entails first running a gap analysis to determine strengths and weaknesses. Financing is usually an identified weakness, though not necessarily as a funding need, but instead in terms of prioritization of funds and financial training. A business plan is developed with input from clinic staff, which might include business training. Additionally, if a clinic chooses, the SafeCare program also assists in the procurement of a loan. After 2 years, the loan is repaid and the analysis is undertaken once more to measure improvement over that time.

Dolfing-Vogelenzang also described that access to finances is another important element of the empowerment discussion. A better understanding of how the funding flows and how investment affects operations enables a greater sense of ownership. Entrepreneurs also learn how to negotiate with suppliers and how to build a case for loans from banks. About 25 percent of the clinics they work with are owned by women. Of those, about 90 percent have applied for loans, with a total of 97 loans disbursed. Sixty-one loans have been repaid. Because the loan repayment has been less than average, Dolfing-Vogelenzang and her colleagues examined the issue further. They found that, in some cases, some of the clinics have run into cash flow problems because insurance payouts from the national system are delayed.

In a brief discussion following the presentation, Dolfing-Vogelenzang noted that the staff at these clinics are not always health professionals (such as nurses, midwives, and physicians) but are sometimes a female relative of a health care professional. In one case she described, an entrepreneur took over a clinic after her husband, a physician, passed away; she was able to implement a number of changes, including an expansion that would not have occurred under her husband's leadership. Dolfing-Vogelenzang also clarified that access to funding was not always the issue; rather, the structure of staffing could be the issue, specifically the absence or presence of the physician-owner.

## GLOBAL LAB FOR INNOVATION<sup>2</sup>

The University of California, Los Angeles (UCLA) Global Lab for Innovation defines innovation as “a product, service, business model, or work process that accelerates the transformation of care. It may be point innovation or comprehensive, and it is technology-enabled but [focused on more

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<sup>2</sup> This section summarizes information presented by Molly Coye, University of California, Los Angeles (UCLA).

than] the technology.” The Global Lab scans domestic and international markets for innovations that reduce the cost of and improve access to care. Molly Coye and her colleagues specifically target delivery systems and their decision makers to prioritize and implement successful innovations.

Coye noted that implementers often recognize that there are different ways to accomplish a goal, but uncertainty exists around which way is the most appropriate. The Global Lab for Innovation seeks to “de-risk” the choice by providing useful, systematic information across multiple platforms. This information is presented in a “scorecard” that allows decision makers to choose criteria suitable for their own context and find the innovations that best fit. Coye stated that anyone can post an innovation, and her team scrutinizes those innovations to determine the characteristics of the innovation as components of the “scorecard.” At the same time, the Global Lab contacts other health systems that have adopted the innovations, because their experiences and results serve as a practical test of whether the innovation can be successfully adopted. Coye explained that innovations are “bucketed” by results, impact, and implementation time (see Figure 6-2). The first step is to separate out potential innovations that

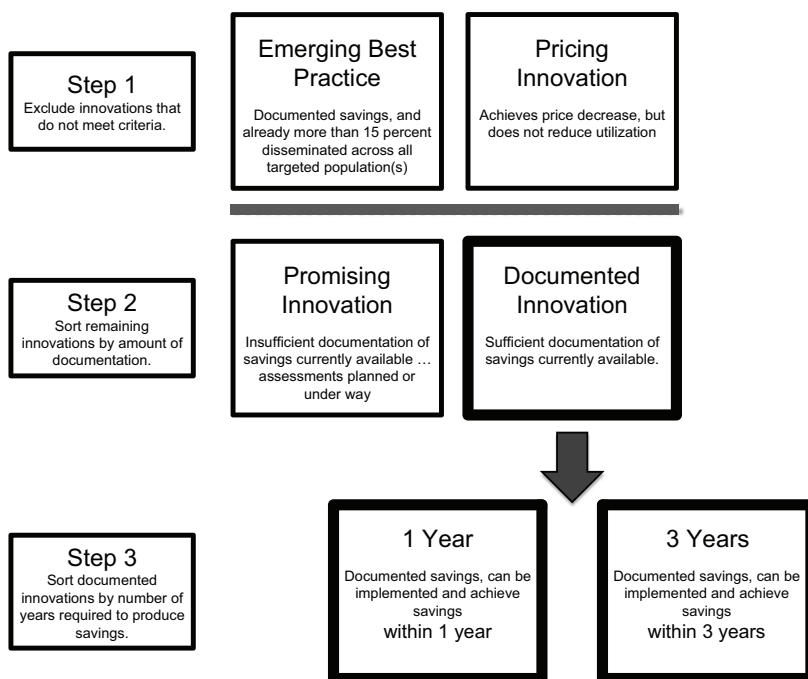


FIGURE 6-2 “Bucketing” innovations.

SOURCE: Adapted from Coye, 2014.

are qualified because they are already well recognized in the field and are used by 15 percent of possible adopters (“emerging best practices”), or because they are not reducing use of services but do achieve price reduction (“pricing innovation”). Then, innovations are separated into a “promising innovation” category (that is, the innovation does not yet have results), or into a “documented innovation” category. Documented innovations are further separated by the amount of time to achieve savings (within 1 year or in less than 3 years).

The scorecards created by the Global Lab for Innovation include information that adopters would like to know about each innovation in order to find “best fit” innovations for their organizations, including such questions as, “How does it increase access? Is it solving geographic problems? Is it solving linguistic problems? What is the method or the means? How does it decrease cost?” Coye noted that this last question is critical, and innovators often combine one or more of five means: (1) substituting lower-cost labor or information technology systems, (2) relocating to a lower level of care (such as in the home instead of in the clinic), (3) using telemedicine, (4) encouraging cost-effective decision making by patients or clinicians, and (5) managing the use of diagnostic tests. In addition to cost, other domains assessed include dissemination potential, access, customer centricity, and health outcomes. Future potential domains could also include empowerment and the impact on the health environment.

### SUPPORTING SCALING OF IMPACT OF GLOBAL HEALTH ENTERPRISES<sup>3</sup>

The Social Entrepreneurship Accelerator at Duke (SEAD), mentioned in Chapter 3, is a program designed to build capacity and provide a conduit to convene multiple programs across the university. It has five components:

1. Identification of the best enterprises working in the global health space,
2. Entry into an accelerator platform,
3. Creation of an investment impact network,
4. Engagement of faculty and students, and
5. Research and data collection.

SEAD brought in 11 organizations in its first year, and 6 organizations in its second year (some organizations include Sughavazhvu, a rural primary care clinic in India; salaUno, an eye care clinic in Mexico; and Jacaranda, a

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<sup>3</sup> This section summarizes information presented by Krishna Udayakumar, International Partnership for Innovative Healthcare Delivery (IPIHD).

maternity clinic in Kenya described by Petra ten Hoope-Bender in Chapter 4). Organizations are brought through the accelerator over a period of 3 years, with program evaluation, expert coaching and mentorship, online tools, and connections to public- and private-sector partners. In the first year of the program, Udayakumar and his colleagues did a gap analysis and customized interventions for each of the organizations in the program. They identified six challenges these enterprises faced in trying to scale impact:

1. Strategic planning: How do you balance the day-to-day activities and concerns with the direction of the enterprise?
2. Funding and investment: Many enterprises took “scattershot” approaches because they did not understand what type of funding would be best for their growth trajectory.
3. Performance management: Enterprises need to be learning organizations rather than intuitive in their approach.
4. Innovation development: What are the key characteristics of the innovation, and how is it delivered? How do unit economics change when operations are scaled?
5. Organizational leadership: How do you grow human capital through recruitment, retention, and professional development?
6. Ecosystem: Enterprises need to learn about the environment in which they operate.

Udayakumar also shared a few lessons learned, namely that assessing an organization’s stage of development and capabilities was a time-consuming process that required diving in deeply over several months. They also learned that focusing on specific regions would create greater impact than identifying organizations from all over the world; therefore, as mentioned previously, future cohorts will be in South Asia and the East African region. In East Africa in particular, the focus will be on enterprises that strengthen and empower women and girls, including those enterprises that are led by women and that work to improve the health of women and girls.

Scaling up specific programs is only one part of the mission, Udayakumar asserted. They are also focusing on accelerating real-world application of innovations through a series of “living laboratories” in Amsterdam, Nairobi, and Shanghai. These living labs will use a defined population (in these specific circumstances, the urban populations of the previously mentioned cities) as a means of testing a set of innovations in an actual health system, focusing on end-user engagement and collaborative problem solving. Udayakumar explained that three domains are of interest: research and innovation to meet health challenges; talent and education to address workforce development needs; and a culture of entrepreneurship that yields impact.



## NURSING AND MIDWIFERY ENTERPRISE: MODELS AND LESSONS LEARNED<sup>4</sup>

Gina Lagomarsino and Carleigh Krubiner shared core ingredients of successful approaches to improve health systems and health outcomes, as well as to empower women. Lagomarsino reiterated that there is a disconnection between a fragmented private sector with small-scale programs of dubious quality and a bureaucratic public sector that does not hold the public's trust. In between are a number of innovators with potential solutions who are not typically in an enabling environment to obtain capital investment, government contracts, or capacity to scale up. Her program, the Center for Health Market Innovations (CHMI) at the Results for Development Institute (R4D), identifies successful models and supports scale-up with resources and connections. The CHMI established a mechanism by which information on specific models is collected via a network of organizations. Through the analysis of the full range of programs, trends can be observed. These trends not only characterize successful programs in terms of health care delivery and patient outcomes, Lagomarsino commented, but also could highlight elements of the models that can empower women.

She also emphasized the need for appropriate adaptability. Being able to isolate the elements that make a program successful does not translate to just taking those elements, moving them into a different context, and expecting it to work. Effort needs to be applied to assessing that adaptation within the new context. Krubiner and Lagomarsino then presented the findings of a paper they wrote with Marla Salmon; in this paper, they reviewed programs that empower women and strengthen health systems and services through nursing and midwifery (Krubiner et al., forthcoming).

### Preliminary Findings from the Global Landscape

Krubiner continued the discussion by delving into the potential empowerment opportunities associated with innovative approaches. She noted that while there is recognition of positive associations between health improvement and women's empowerment (in both directions), much of the analysis focuses on the empowerment of health consumers, overlooking provider-side inputs. Assessments usually report on the number of interventions developed, coverage of family planning services, and other indicators. She remarked that many innovative approaches to health service delivery

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<sup>4</sup> This section summarizes information presented by Gina Lagomarsino and Carleigh Krubiner, Results for Development Institute (R4D).

also provide opportunities to empower providers, particularly female health workers.

Through a landscape review of the CHMI database, she identified 94 programs from 56 low- and middle-income countries that specifically include nurses (46 programs), midwives (25), or both (23) to find the key inputs that are associated with empowerment. There are a number of definitions and measures of empowerment, but the CHMI used a pluralistic approach including education, employment, income generation, leadership, ownership of assets, political participation, enhanced self-esteem, and others (see Table 6-1).

Krubiner noted that most of the programs did not specifically self-measure for empowerment, so the CHMI needed to thoroughly examine each program for the above indicators that are most commonly associated with empowerment. The health focus of these programs are skewed toward maternal and child health care, and to a lesser extent, family planning, reproductive health, and HIV/AIDS. Other programs focused on communicable disease, chronic disease, eye care, nutrition, dentistry, and mental health. The majority of programs were not-for-profit, with funding coming from international donors. The model structures that seemed most promising for empowerment included provider training; information and communications technology (ICT); cooperatives, networks, and associations; and social franchises.

### **Provider Training**

Professional training has clear empowerment inputs through certification for income-generating positions, enhanced self-confidence, clinical leadership roles, continued education, and enhanced respect of peers and community members. Four types of training inputs were identified: pre-service training and certification, specialty training, continuing education, and bridging opportunities to enter the health workforce, which can serve as an entrance to nursing or midwifery practice. The 47 professional training programs identified under this heading included scholarships or direct funding for students, quality improvement of existing curricula, “training of trainers,” supplemental training, enhanced task-sharing opportunities, recruiting of girls, and strengthening capacity of community health workers.

### **Information and Communications Technologies (ICTs)**

ICTs for health are primarily used for telemedicine, communication outside the clinical setting, decision support applications, data collection and management systems, and financial transactions. ICT platforms pro-

TABLE 6-1 Empowerment Measures

Dimension	Household	Community	Broader Arenas
Economic	Women's control over income; relative contribution to family support; access to and control of family resources	Women's access to employment; ownership of assets and land; access to credit; involvement and/or representation in local trade associations; access to markets	Women's representation in high-paying jobs; women CEOs; representation of women's economic interests in macroeconomic policies, state and federal budgets
Sociocultural	Women's freedom of movement; lack of discrimination against daughters; commitment to educating daughters	Women's visibility in and access to social spaces; access to modern transportation; participation in extra-familial groups and social networks; shift in patriarchal norms (such as son preference); symbolic representation of the female in myth and ritual	Women's literacy and access to a broad range of educational options; positive media images of women, their roles, and contributions
Familial/Interpersonal	Participation in domestic decision making; control over sexual relations; ability to make childbearing decisions, use contraception, access abortion; control over spouse selection and marriage timing; freedom from domestic violence	Shifts in marriage and kinship systems indicating greater value and autonomy for women (e.g., later marriages, self-selection of spouses, reduction in the practice of dowry; acceptability of divorce); local campaigns against domestic violence	Regional/national trends in timing of marriage, options for divorce; political, legal, religious support for (or lack of active opposition to) such shifts; systems providing easy access to contraception, safe abortion, reproductive health services

Legal	Knowledge of legal rights; domestic support for exercising rights	Community mobilization for rights; campaigns for rights awareness; effective local enforcement of legal rights	Laws supporting women's rights, access to resources and options; advocacy for rights and legislation; use of judicial system to redress rights violations
Political	Knowledge of political system and means of access to it; domestic support for political engagement; exercising the right to vote	Women's involvement or mobilization in the local political system/campaigns; support for specific candidates or legislation; representation in local bodies of government	Women's representation in regional and national bodies of government; strength as a voting bloc; representation of women's interests in effective lobbies and interest groups
Psychological	Self-esteem; self-efficacy; psychological well-being	Collective awareness of injustice, potential of mobilization	Women's sense of inclusion and entitlement; systemic acceptance of women's entitlement and inclusion

SOURCE: Malhotra et al., 2002.

vide greater opportunities for communication, mentorship, peer support, and outside consults with clinical experts. These tools were found to promote self-esteem, autonomy, greater social and professional connection, access to capital, and better practice through up-to-date knowledge. Nine programs were identified as using ICT as their core platform.

### **Cooperatives, Networks, and Associations**

Collaborative approaches have the power of bringing people together with a shared purpose for collective bargaining, negotiating, social support and peer mentoring, participatory governance, and union activities. Additionally, such groups can facilitate access to capital through pooled-risk structures. These organizations often engage in strategic partnerships with other organizations, and sometimes the government, to leverage partners' capabilities.

### **Social Franchises**

The franchise model provides nurses and midwives a number of empowerment opportunities, including business ownership under an established brand, autonomy, and income generation. Usually, franchisees are trained on both the clinical and business side, as part of membership. The brand recognition, which included a certain standard of quality, conferred higher status on the nurses and midwives. Twenty-three social franchise models were identified, ranging from maternal and child health clinics to clinics with a broader focus, stand-alone clinics to those embedded within larger health facilities, and one-woman shops to those with multiple staff personnel.

### **Observations and Discussion**

Krubiner observed that while a number of programs provide these empowerment inputs, there is little documentation explicitly reporting on empowerment aims. The few programs that did document this listed empowerment as part of the organizational mission. This brings up the issue of intentionality, she argued, and the need to specifically include empowerment, of both consumers and providers, as a programmatic goal and capture relevant indicators in monitoring and evaluation. However, she cautioned that this analysis looked at "hallmarks" and inputs commonly associated with empowerment. They did not study whether any actual empowerment resulted because of the lack of available data. Finally, she remarked that many of these models are in the pilot stage, and the long-term sustainability of these approaches is still unclear.

In the discussion following the presentation, Krubiner spoke further about the need to establish indicators for empowerment outputs. Participants speculated that this could take a number of forms—from the individual level of generating income or preventing violence at home to the governmental level of tying women’s empowerment to gross domestic product (GDP) growth. One participant noted that many of these models might not be financeable by the private sector, but they could benefit from public funding, given enough interest on the part of the government.

Other participants questioned whether additional empowerment outputs might be measured. For example, is ownership of a business leading to greater autonomy an integral element of empowerment? Others remarked that accountability and a sense of responsibility could also be useful measurements of empowerment.

The role of nurses and midwives was called into question given that each has a specific definition (and role), but both often serve multiple capacities depending on need and context. At the same time, other female health care workers—auxiliary workers, community health workers, and others—are often conflated under the heading of nurse or midwife. This can lead to confusion in terms of measuring the empowerment of providers that impacts their day-to-day responsibilities as nurses and midwives are often tasked beyond their training or job description.

Finally, participants delved further into the idea of intentionality. One participant remarked that a way to ensure its inclusion is to embed empowerment into grant making. Another participant noted that starting with the needs of women, whether the consumer or the provider, is inherently empowering. A third participant cautioned that empowering women, whether consumers or providers, occurs within a context of including men. On a professional level, this also means working toward team-based approaches in which tasks are not assigned by profession but rather by skill and context, and traditional hierarchies are flattened.

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## 7

# Social Enterprise and Investment in Health

### Key Messages

Specifically the model that we talk is about scaling impact, not about scaling organizations and not about scaling volume of services provided. And we know that we have to scale impact because the problems far exceed the current solutions.

—Krishna Udayakumar

I am a huge believer that the funding should be structured for the need and not the other way around. Many funders tend to have very strict requirements on how their capital is deployed, and it ends up having the recipients or the organizations [struggle] to fit that.

—Beth Bafford

Up until now we have not figured out how to make leadership what economists call endogenous because now it is totally exogenous, like a superstar that comes out of nowhere. The system has to make leadership endogenous.

—Oscar Picazo



How does empowerment start? In the past it was often self-empowerment, but can we find the few people [who] we can empower [so] that [they] can help others be empowered?

—Monique Dolfig-Vogelenzang

Social enterprise represents one possible approach to leveraging the strength and reach of an empowered nursing and midwifery workforce. Because many social enterprises have a commercial focus, but are small and medium sized, they often lack access to traditional means of funding. Speakers shared perspectives on models of social enterprise, such as franchises, that could embed nurses and midwives in communities, as well as innovative financing mechanisms to fund them.

### THE ROLE OF SOCIAL ENTERPRISE<sup>1</sup>

Social enterprises are businesses whose primary purpose is the common good; they use business practices and the marketplace to advance social justice and development. Krishna Udayakumar explained that there are characteristics that define a social enterprise: it addresses a social need, it generates income mainly through its commercial activities, and it focuses primarily on the common good. Additionally, social enterprises have clear rules about the reinvestment of profits to further its “social mission.” Social Enterprise Canada uses a graph model to explain that social enterprises have a “blended value return on investment”; they fit between charities, whose focus is social return on funding, and traditional for-profit enterprises, whose focus is financial return on investment (see Figure 7-1).

Udayakumar cautioned that these definitions leave room for interpretation, depending on the lens through which they are viewed. He noted that some traditional for-profit structures, such as pharmaceutical companies, produce social goods and could be considered social enterprises under these definitions. At Duke University, he observed that social entrepreneurs are viewed as change agents who:

- Adopt a mission to create and sustain social value,
- Recognize and pursue new solutions,
- Engage in continuous innovation and learning,
- Act without being constrained by current resources, and
- Are accountable to the populations they serve.

<sup>1</sup> This section summarizes information presented by Krishna Udayakumar, International Partnership for Innovative Healthcare Delivery (IPIHD).

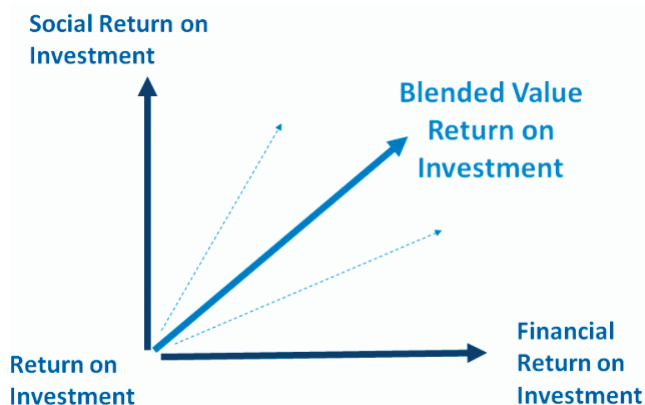


FIGURE 7-1 Social enterprise seeks a blended return on investment.

NOTE: For more information, visit the Social Enterprise Canada website: <http://www.socialenterprise.ca/en/learn/nav/whatisasocialenterprise.html> (accessed November 4, 2014).

SOURCE: Social Enterprise Canada, n.d.

Social entrepreneurship runs the risk of constantly creating innovations, or having “pilot-itis.” Udayakumar noted that the main focus in the field should be on scaling up, and specifically scaling up impact rather than scaling organizations or volume of services. Ideally, solutions presented by social entrepreneurs expand faster than current problems to reduce their magnitude. He described three ways to scale impact: scaling out, scaling deep, and changing the ecosystem. For scaling out, he proposed building solutions with potential to spread to new markets and locations, or increase reach. This could include branching, affiliating, or disseminating. For scaling deep, he proposed creating new services for the same end users, or enhancing quality of existing services. Lastly, to change the ecosystem, he proposed modifying the context and behavior to enhance the work of other organizations or individuals.

## INVESTING IN GLOBAL HEALTH<sup>2</sup>

Financing for social enterprise can be creative, including debt, equity, grants, donor funding, and public funding. Beth Bafford explained that even within traditional means, innovative financing mechanisms can be constructed depending on outcomes desired. She described the Global Health Investment Landscaping Project (GHILP), whose goal was to provide a

<sup>2</sup> This section summarizes information presented by Beth Bafford, Calvert Foundation.

picture of current sources of debt and equity financing for global health entrepreneurs in East Africa and India. Its objectives were three-fold: to understand the range of available financial options, to explore potential partners, and to share findings with other interested investors. GHILP focused on debt and equity providers, health or health-as-vertical organizations, and funds with an explicit impact orientation.

### Lessons Learned

Bafford described four important lessons that were learned in this exercise. First, there is a great and growing interest in investing in health care. There are multiple reasons for this, including a growing middle class with an increased willingness and ability to pay and better technology and access to information. Multinational companies also see emerging markets as growth opportunities, and high-income country “medical elite” see opportunities to spread capabilities and capacities.

Secondly, she said, there is a financial gap in the sector that is ripe for impact investors. Currently, there is a lot of focus from donors and grant providers on rural populations and the “bottom of the pyramid” (BOP). There is also traditional private equity and debt seeking high returns from urban and suburban high-income populations. In between is a gap where both BOP and middle-class populations can be addressed via debt and equity investment models. In particular, low-margin, high-volume models for the BOP and higher-margin models for the middle class could be particularly suitable for social enterprises that could balance return and impact.

The third lesson Bafford described is the need for better communication and coordination. There is not a lot of information passed between actors in this space, particularly between those in the public sector and those in the private sector, she said. There is also not a lot of discussion around policies that enhance private-sector delivery, or coordination around services.

Lastly, Bafford said that there are key parts of the value chain that need greater attention from government and philanthropy. Market-based business models can address some of the issues of health care delivery and ease the burden on the public sector. However, government and philanthropy need to focus on providing the proper support for social enterprise to thrive, particularly professional education and research and development.

### Innovative Financing Mechanisms

Bafford went on to describe two innovative financing mechanisms that her institution has developed to fill some of the unmet needs in funding. One is a type of social impact bond in which the Calvert Foundation loaned funds to a childhood asthma management organization to scale up its pro-

gram. This arrangement covers upfront funding for prevention interventions as well as evaluation, which yields cost savings to the health system each year over 3 years. From these savings, the health care provider who realizes the savings pays back the loan with interest over those 3 years. The second mechanism is a bridging loan to close the time gap between grant approval for commodities and supplies on the donor side and disbursement of funds to the nongovernmental organization (NGO). Because the Calvert Foundation can provide the funds more quickly, the NGO has better negotiating ability when ordering the goods. When the funds are disbursed, they go toward paying back the loan.

### INNOVATIONS IN THE PROVISION OF HEALTH SERVICES USING EMPOWERED NURSES AND MIDWIVES IN THE PHILIPPINES<sup>3</sup>

Oscar Picazo presented some thoughts about health systems and the health care workforce that were drawn from two decades of personal experiences working in health economics, financing and policy, and human resources for health in the Philippines and around the world. A paper he developed to enrich discussions at the workshop highlighted four innovations using nurse or midwife empowerment as a basis for their establishment. Each of these private-sector initiatives comes from the Philippines and focuses on deployment of nurses and midwives to underserved areas by employing more sustainable business models that emphasize the health needs of low-income populations. Below are the four innovations profiled in Picazo's paper that can be found in Appendix D of this report:

1. Well-Family Midwife Franchise Clinics
2. Mother Bless Birthing Clinics, a public-private partnership
3. Blue Star Pilipinas Clinics
4. EntrepreNurse Cooperatives

#### Innovative Models

##### *The Well-Family Midwife Clinics*

The Well-Family Midwife Clinics was created in 1997 as a U.S. Agency for International Development (USAID) project, and then became a social

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<sup>3</sup> This section summarizes information presented by Oscar Picazo, Philippine Institute for Development Studies.

franchise with trained nurses taking on the role of the midwives.<sup>4</sup> There are now 120 clinics in Manila and 28 provinces. Picazo explained that this innovation scaled up successfully and has become mainstream.

### *Mother Bles Birthing Clinics*

Mother Bles Birthing Clinics was established in 2009 by a local foundation. It is a public–private partnership with local governments providing land or facility space, and the foundation providing seed capital, training, and management systems. Currently there are 50 clinics in 10 provinces all accredited by PhilHealth.

### *Blue Star Pilipinas Clinics*

Blue Star Pilipinas Clinics is a nonprofit franchise of clinics, originally created by two international NGOs, but currently run by a local corporation that acts as the franchiser. Midwives are the franchisees. There are now 200 clinics in peri-urban areas.

### *EntrepreNurse Cooperatives*

The Well-Family Midwife Clinics, the Mother Bles Birthing Clinics, and the Blue Star Pilipinas Clinics are all well established. Picazo then described a fourth model, *EntrepreNurse*, which is gaining more traction in the Philippines. *EntrepreNurse* was established by the Department of Labor and Employment because there was a drop in emigration opportunities for nurses, resulting in high unemployment of nurses in the Philippines. Nurses were organized into cooperatives, with services including home care, primary health care, medical transcription, emergency services, and wellness and fitness. There are now five nurse cooperatives in one region. The idea has been adopted by another region, but because the documentation is poor and there is no donor funding, it is difficult to assess how many cooperatives there are in total.

## Challenges Faced

These models function because there is high availability of nurses and midwives; approximately 260,000 nurses graduate per year, with one-third of them being licensed. They are also dependent on visionary leadership and

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<sup>4</sup> For more information about the Well-Family Midwife Clinics, please visit their website: <http://healthmarketinnovations.org/program/well-family-midwife-clinic> (accessed November 4, 2014).

investment; all of these models were championed by an individual willing to take risks and mobilize novel resources. Picazo noted that one challenge is fostering such leadership within the system, rather than relying on the external individual. He queried, how can leadership be made endogenous? Is it by training, inspiration, coaching, or something else? Finally, he stated that a third element of success is the support of PhilHealth and its expanded reimbursement of reproductive health clinics.

However, there are a few constraints. Regulatory obstacles mean it can take anywhere from 18 months to 2–3 years to receive an operating license because there is no sense of urgency to issue them. Another constraint is professional territoriality that has been especially evident between obstetricians and gynecologists on one side and nurses and midwives on the other. Third, there is inadequate training of nurses and midwives particularly in terms of business management.

### Next Steps

When asked about next steps for improving health systems and empowering nurses and midwives in the Philippines, Picazo proposed three possibilities: scaling, improving reimbursement, and training.

#### *Scaling*

Currently, most of the franchise clinic models focus on reproductive health, maternal health, and family planning. Expanding to include care for patients with malaria, tuberculosis, and mental health would provide more comprehensive and responsive services. Successful programs with integrated services could potentially spread their practices more broadly.

#### *Improving Reimbursement*

PhilHealth currently has a generous payment scheme for birthing services, but Picazo commented that for other services, rates are lower than the prevailing cost for some of these franchises. This limits revenue, which ultimately limits growth.

#### *Training*

Currently, the government and donors offer technical training only to public-sector health workers and not to the private sector. Because many nurse and midwife franchises offer public health services, additional training by government could be obtained to assist nurses and midwives in widening their scope through newly acquired technical skills.

## FRANCHISE APPROACH TO SOCIAL FINANCE AND SOCIAL ENTERPRISE

In the discussion that followed, participants further explored the breadth of training that nurses and midwives receive in formal education. Some participants questioned whether teaching business skills should be a default part of licensing or degree programs, particularly when students are focused on honing clinical skills. Others differentiated between management skills, such as learning how to work as part of a team, and entrepreneurial skills. One participant explained that if nurses are in graduate school or in the field and do not understand business, they will be excluded from decision making. However, if training nurses and midwives to be business-oriented is a key goal, then it is a criterion that should be considered upon entry to training programs.

The franchise model was reiterated as one way to distinguish between those who prefer to focus on clinical practice and those who might desire to be an independent professional and who might display additional skills such as business acumen. In the franchise model, whether it is traditional or more socially driven, the broader organization drives the business centrally and can embed systematic practices, such as back-office operations and accounting. The franchisees plug the system into their own context and offload administrative tasks so they can focus on their clinical practice.

Franchising can also allow a nurse or a midwife to deepen her scope of practice even in different disciplines; for example, the four franchises that Picazo discussed started with family planning, reproductive health, and maternal health as their main scope, but there is an opportunity to include tuberculosis, mental health, and youth reproductive health into their practice. Franchises can also help create networks between practitioners that can leverage economies of scale and collective power, compared to the relatively minimal impact of solo individual practices.

### FRANCHISE EXAMPLE IN GHANA<sup>5</sup>

Monique Dolfig-Vogelenzang described a for-profit franchise network being developed in Ghana to provide care to middle-income families. The model includes four important components: (1) customer focus, (2) efficient operations, (3) quality care, and (4) skilled staff. Its objectives include building a scalable model to improve access to and quality of health care at affordable prices. Its intended outputs include the establishment of 10 family health clinics that increase economic activity in health and associated

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<sup>5</sup> This section summarizes information presented by Monique Dolfig-Vogelenzang, Medical Credit Fund (MCF).

sectors and patient–provider contact, while its outputs include a recognized brand of high-quality health care use that provides a business case for greater investment. Its intended impact includes greater gender equity, job creation, better population health, and increased investment in the private health sector.

The model is based on a partnership, which includes multinational corporations. Dolfing-Vogelenzang cautioned that nonexclusivity is an essential part of the process, particularly when partnering with entities producing goods (such as pharmaceutical or medical device manufacturers). Other partners she recommended include those with expertise in training using multiple media and in different settings, as well as finance entities. At the center of the partnership is the shared services organization that owns the model and its parts, and who franchises the model to network clinics.

Dolfing-Vogelenzang described the steps she and her colleagues have identified to establish the franchise, from inception to feasibility analysis, procurement, contracting, implementation, and monitoring and evaluation. Procurement and contracting requires finding the right person to run the operation and incentivize partners, she explained. It also means connecting to the right people in-country, perhaps with access to high levels of government, to mobilize support and interest. Another participant raised the possibility of twinning or partnering with similar organizations in another country to build capacity.

## REFERENCE

Social Enterprise Canada. n.d. *What is a social enterprise?* <http://www.socialenterprisecanada.ca/en/learn/nav/whatisasocialenterprise.html> (accessed November 4, 2014).





## Part III



## 8

# Transferability of Models and Lessons Learned

### Key Messages

To be able to convince those to participate and to pay, you need to have real added value.

—Monique Dolfig-Vogelenzang

If we are talking about women's empowerment while focusing on midwives and nurses, we should also look at other types of health workers that commit to empower women, like community health workers, for future support.

—Akiko Maeda

There should be a commitment at the provider level to the AAAQ framework around Availability, Accessibility, Acceptability, and Quality of services. There has to be a coherent financing mechanism that really drives population health management as opposed to quantity of services provided.

—Krishna Udayakumar

I think we have real issues about scaling and replication, but we could definitely learn lessons from abroad and internally.

—Deborah Bae

On the afternoon of the second day, participants rotated through three different breakout groups to explore with more granularity issues of financing and training of nursing and midwifery enterprise. They also explored how elements of empowerment and health systems strengthening might be intentionally incorporated into new financing and training models that could be transferred to the United States. The intentionality of women's empowerment was highlighted as an area of particular interest for the small groups to consider. In each group, participants discussed potential transferability of models to new settings and lessons learned relating to context, needs, and culture. They also identified challenges and opportunities, promising models, and potential strategies for success. Participants reconvened in a large group to provide individual insights based on the small group discussions. The following is a summary of the small group discussions presented by the group leaders, and they should not be viewed as consensus.

#### **CHALLENGES AND OPPORTUNITIES: FINANCING NURSING AND MIDWIFERY ENTERPRISES THAT EMPOWER WOMEN AND STRENGTHEN HEALTH SYSTEMS<sup>1</sup>**

Group leader Monique Dolfing-Vogelenzang raised the issue of nurse franchising for developing countries that could also have implications for the United States. The franchise would include a toolbox with a set of standards, guidelines, and services that would be made available to all of the clinics, and tailored in primary health care services to specific patient groups. One main focus would be the marketing around a strong branding identity with pricing, quality elements, back-office operations, group purchasing power, referral system, and information and communications technology (ICT) tools.

Because the franchisees would be part of a strong network, they would also be able to leverage collective power for negotiation and discussion around regulation. One major stakeholder would be schools that train nurses, midwives, doctors, and/or community health workers. And in addition to donor funds at the start, Dolfing-Vogelenzang noted that the early inclusion of investors would yield greater sustainability.

The model could commence with one or two facilities that serve as central hubs where processes and infrastructure would be vetted. Additional franchises could then be added in replication. Franchise owners would receive training, the toolkit, and access to financing as part of the membership fee. Clients would pay for services, whether out of pocket or by insurance

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<sup>1</sup> This section summarizes information presented by Monique Dolfing-Vogelenzang, Medical Credit Fund (MCF).

card, and process and costs would be continually evaluated to ensure affordability and sustainability.

One consideration raised by Dolfing-Vogelenzang involves convincing consumers and providers to participate and to pay. This could possibly be addressed by offering health financing through the government, or by giving schools an important though not necessarily leadership-oriented role. Standards and guidelines would also add value by providing a universal level of quality within a country. A flexible model would allow franchisees a certain degree of freedom to remain competitive with other facilities in the area.

A number of challenges implicit in this model were also articulated by individual members of the group:

- The lack of and need for business and startup expertise,
- The economics of patient capacity to pay,
- Patient mix (including ability to pay, illness, and severity of illness),
- Restrictive regulation,
- Access to capital, both short and long term,
- Quality standards and support,
- Knowledge around best practices, and
- Lack of trust, including brand trust.

A model such as this, said Dolfing-Vogelenzang, could provide a number of opportunities to address these challenges, such as engaging patients and communities, meeting the needs of the population, developing different models of financing, involving different types of providers, and involving schools.

### **STRATEGIES AND SUPPORT: START-UP, SCALE-UP, SUSTAINABILITY, AND TRANSFERABILITY OF ACTUAL AND THEORETICAL MODELS GLOBALLY AND TO THE UNITED STATES<sup>2</sup>**

Small group leader Akiko Maeda suggested that gaps in existing services and care models might actually be opportunities to create or adopt new models that would build on the comparative strength of nurses and midwives in the United States and around the world. She also noted that, in thinking about women's empowerment, some consideration could be given to other health workers who commit to empowering women. While a number of potential areas of need exist, one particular space is long-term care management, particularly community-based care coordination.

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<sup>2</sup> This section summarizes information presented by Akiko Maeda, The World Bank.

Maeda offered a few thoughts on how to explore this area, as discussed in her breakout group:

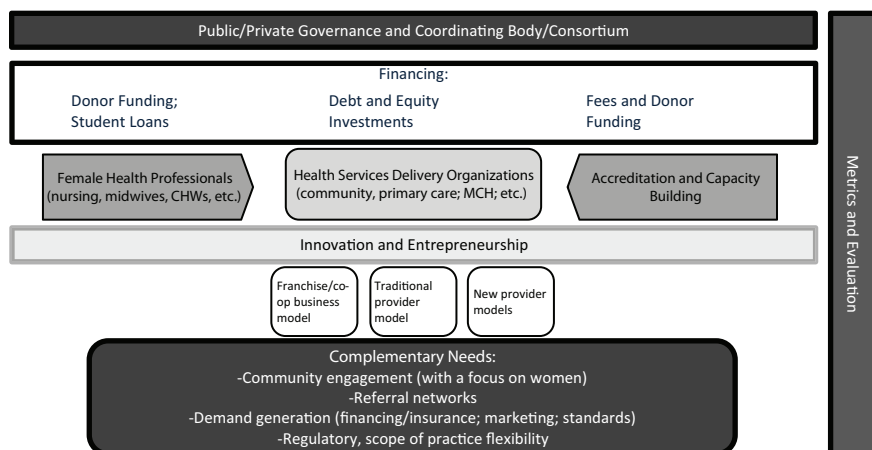
- Examine the landscape for opportunities without focusing too narrowly or broadly.
- Be aware of the acceptability of a strategy, and how to mainstream such models from the perspective of consumers, other professionals, and the market.
- Provide nurses and health workers additional support in business management.
- Understand the additional value that nursing and midwifery bring to coordination and management leadership.
- Provide long-term in-service training and support mentorship.
- Support a model in which the workforce is connected with the community, so that both can be empowered.
- Bridge secondary school graduates and postsecondary graduate programs with remedial education and rural pipelines, to provide a career pathway for disenfranchised or marginalized populations.
- Ensure fair, market-comparable wages while still maintaining affordability.
- Shift the paradigm away from immutable groups of professionals with specific skills toward a matching of health care needs and skillsets that creates value.

**PROMISING APPROACHES:  
BRINGING TOGETHER THE KEY ELEMENTS OF NURSING/  
MIDWIFERY PRACTICE AND EDUCATION/TRAINING  
AND SOCIAL ENTERPRISE/SOCIAL FINANCE<sup>3</sup>**

Group leader Krishna Udayakumar explained that the discussion in his group explored the pathway from the inputs of education, training, and practice of nurses and midwives and social investment and enterprise to the outputs of health systems strengthening and women's empowerment. He presented one potential framework to illuminate that pathway, which could be applied to multiple models of health care delivery in the United States and abroad (see Figure 8-1). In the middle of Figure 8-1 is the strengthening of organizations that deliver health and health-related services, especially those focused on community and primary care, as well as maternal and child health. These organizations include business models, traditional provider models, and, eventually, new provider models. Adequate educa-

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<sup>3</sup> This section summarizes information presented by Krishna Udayakumar, International Partnership for Innovative Healthcare Delivery (IPIHD).



**FIGURE 8-1** A framework for strengthening health systems and empowering women through nursing and midwifery and social enterprise: The long-term vision. NOTE: CHWs = community health workers; MCH = maternal and child health. SOURCE: Udayakumar, 2014.

tion and training of female health care professionals (including nurses, midwives, community health workers, physicians, etc.) can strengthen these organizations, as can accreditation and capacity building functions. Feeding into this is a culture of entrepreneurship that not only builds from known models but also continues to innovate.

Each of the pieces are financed by different mechanisms: education and training could be funded by a combination of donor and government sources as well as student loans; provider organizations could be supported through debt and equity investments; and accreditation organizations could be funded by fees from the providers as well as some donor and government organizations.

Additional complementary needs to enhance the framework include community engagement, referral networks, demand generation, and flexibility in both regulatory and scope of practice issues. Udayakumar remarked that it is unlikely any single actor could create such an ecosystem, and that a consortium governance model might be most effective.

While this is a long-term vision, individual participants emphasized that team-based professional education and clinical training models—particularly focused on community primary care and leadership development—could be important elements for the short term. Udayakumar also stressed the transformative potential of using established best practices, building models, and providing a defined core basket of services to horizontally integrate



across disciplines. He suggested that provider organizations could make a commitment to women's empowerment by adding related metrics into their evaluations.

#### FINANCING REVERSE INNOVATION<sup>4</sup>

Following the group leader presentations, Deborah Bae remarked that a number of the issues raised in lower- and middle-income countries have direct and indirect application to the United States, where there are pockets of poverty and high variability in access to services. She cautioned that rather than thinking about two systems, one for OECD-member (Organisation for Economic Co-operation and Development) countries and the other for developing countries, there could be convergence around a single system, because a number of themes and issues are relevant across the globe.

She also highlighted the importance of integrating consumer engagement into health systems; quality metrics could resonate with the people whose health is being improved, particularly patient-reported outcomes. In fact, one good indicator of empowering patients is to provide them the tools to measure their own health, rather than always having to go to the clinic or doctor's office.

From a funding perspective, she emphasized the value in learning from successful existing models then adapting and improving those models rather than continuously funding new pilots. She proposed a few ideas, such as social exchange labs and aggregators, where independent evidence can identify universal core elements of successful programs. But one frustration she voiced is that for more than four decades, programs and innovations have been funded without seeing big changes in health services provision in the United States. She cautioned that donor funding can be a double-edged sword; funding can and should support many innovative and even basic initiatives like scholarships, but they are not sustainable. She closed by noting that partnership and collaboration hold the keys to moving toward sustainability, and models from multiple countries could produce benefits in the United States.

#### REFERENCE

- Udayakumar, K. 2014. *Promising approaches and models: Report*. Presented at the IOM workshop: Empowering women and strengthening health systems and services through investing in nursing and midwifery enterprise: Lessons from lower-income countries. Bellagio, Italy, September 10.

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<sup>4</sup> This section summarizes information presented by Deborah Bae, Robert Wood Johnson Foundation (RWJF).

## 9

## Models for the United States and the Larger Global Context

On the final day of the workshop, participants once again convened in breakout groups to discuss the themes that were raised throughout the workshop and to propose further lines of inquiry. Individuals were selected from each small group to report their views as they related to the statement of task. Points and issues raised by these individuals were informed by their small group discussions and were open to comments and scrutiny by other participants. The comments in the sections below are summaries of the group discussions presented by the group leaders, and they should not be viewed as consensus. The workshop closed with participants reflecting on the ideas and examples shared by the participants throughout the 3-day workshop and how each might use the information to inform their future work.

### ESTABLISHING NURSE- AND MIDWIFE-LED ENTERPRISES<sup>1</sup>

Akiko Maeda noted that current health systems are not sustainable. She proposed that nurse- and midwife-led enterprises have the potential to effect a paradigm shift toward greater sustainability, but it would require detailed market research to evaluate outcomes. Examination of successes and failures in the United States and abroad would add to the knowledge base. If no models exist in a given setting, an investment climate assessment would provide crucial information. In particular, this would include con-

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<sup>1</sup> This section summarizes information presented by Akiko Maeda, The World Bank.

ducting a landscape analysis of entrepreneurial leadership and identifying an entity to serve as a potential incubator.

In many countries, private investment is flowing in, so Maeda questioned how these funds could be directed toward community-based primary care services led by nurses or midwives. One difficulty is that funds go into high-end technologies that offer quick returns, and social franchises tend to have longer-term benefits. A case would have to be made for the advantages of a sustainable long-term investment, she said; however, once funding was diverted toward these enterprises, Maeda observed that it would need to be scaled up to allow entities to grow. This would also require a degree of tolerance as a certain number of businesses would likely not succeed. And finally, she noted a greater need for communication, social marketing strategy, and awareness building to raise the acceptability of privatization and to build a well-respected brand.

## EXPANDING SOCIAL ENTERPRISE AND PROOF OF CONCEPT<sup>2</sup>

Petra ten Hoop-Bender explained that her group raised some of the same points as the previous group, but also considered how to scale up models that are already established and functioning. She proposed expanding the Philippine franchise model to include primary care. The One Family Health model from Kenya and Rwanda could also expand to include reproductive health. What is important, she argued, is that the proof-of-concept could be realized within a short timeframe rather than risk stagnation of pilot tests. One approach for the United States and elsewhere would be to establish a challenge in which a prize is awarded to whoever expands from a nursing, midwifery, consumer goods, or pharmacy model to a workable primary care model within 2 years.

An essential element of this she spotlighted was local leadership. Some of the successful models that had previously been described were started by Westerners, but even within the United States, long-term sustainability of small and medium-size enterprises would require local ownership. She noted that such models could spread beyond primary care to include other community health prevention interventions such as well-being and fitness. Finally, she emphasized the importance of strong partnerships and buy-in from funders and health and business professionals.

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<sup>2</sup> This section summarizes information presented by Petra ten Hoop-Bender, ICS Integrare (Instituto de Cooperación Social Integrare).

### NURSE-LED ENTERPRISE FOR PREVENTIVE CARE<sup>3</sup>

Deborah Bae explained that in the United States, the health care system is very fragmented and contains a number of gaps, particularly in the preventive health realm. She described a patchwork system of hospitals, doctor's offices, minute clinics, community health centers, and many others. She suggested that in the midst of this there could be a role for a nurse-led enterprise that would mirror primary care and offer preventive services reimbursable by insurance. Rather than a bricks-and-mortar clinic, it could instead take the form of a benefits package that could be inserted into existing systems such as health centers and colleges. The package could include a unique mix of mental health counseling, smoking cessation guidance, weight loss programs, nutrition advice, and other population health-based preventive measures. She noted that under the guidelines of the U.S. Patient Protection and Affordable Care Act, 50 percent of premiums can be used to incentivize healthy behavior, so that could be a potential source of funding.

Beth Bafford further emphasized that this concept is not just focused on providing health services; it is focused on building relationships to personalize those services. Patients and clients would know their contact within the system—the health professional they would reach out to would serve as an advocate, mentor, and guide in a holistic approach to health. On the financing side, she acknowledged growing interest in nurse-driven enterprises given the current investment climate. Such a model has potential for revenue and growth, so an investor or venture capitalist could see financing possibilities.

Bae underscored how nurses are well positioned to lead such models, with the additional advantage of promoting the women's empowerment agenda. Further developing partnerships between nursing and business schools to create a new cadre of nurses with the specific skills and tools necessary for such models is a key facet as well. Within these models, female nurses with an inclination toward business can be intentionally trained for supervisory positions and entrepreneurial roles. Leadership development for nurses that extends beyond the business acumen and intentionally addresses empowerment issues for greater work autonomy and job satisfaction might similarly be considered for midwives and community health workers. This model has the potential to shift thinking from a treatment mentality with "patients" to more service-oriented thinking with "clients." Such a business model might explore unique modes of entry to the health system that could, for example, engage women at hair and nail salons. This

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<sup>3</sup> This section summarizes information presented by Deborah Bae, Robert Wood Johnson Foundation (RWJF), and Beth Bafford, the Calvert Foundation.

would have the dual benefit of increasing a nurse's client base while providing health education to women in a safe environment.

Bae reflected upon conversations she had with focus groups in the Appalachia region as well as in cities, rural areas, and suburban communities in the United States. The insight for her was a request for better engagement of women in health and health care. Knowing that women play such a vital role in keeping people and families healthy, and that such a large percentage of women work in nursing and midwifery, Bae speculated that greater opportunities for nurse- and midwife-led enterprises could be one strategy for strengthening health systems while empowering women in the United States and around the world.

### THE WAY FORWARD

Participants closed the workshop by discussing themes raised throughout the 3 days and proposing potential next steps, including areas of research, scale-up, and investment in nurses and midwives. They also continued to explore challenges and opportunities in moving the needle toward improved population health via health systems strengthening and women's empowerment. Some concepts discussed by individual participants included

- Health is not just health care but encompasses contexts in which people live, so to improve health, women have to be engaged. One participant explained that women are the “keepers of health” in people's lives; health is a highly esteemed value for women.
- Women are often deprived of opportunities to focus on business, which results in job prospects that are limited to the public sector. Bringing business skills into nursing and midwifery training, possibly during secondary school, could be one approach to expanding those opportunities.
- One participant cautioned against “over-engineering.” People with entrepreneurial spirit will develop solutions that others have not thought about, so long as they are empowered and provided a platform on which to build their innovation.
- Harmonization and integration were also raised as key elements in bringing disparate solutions together globally. Mechanisms to share knowledge and data can help reduce issues such as “pilot-itis” and can inform novel education and training approaches within the practice environment.
- One participant proposed that solutions to improve health could be rooted in the community, with services built and providers produced to respond to community identified needs.

- Not everyone is suited for entrepreneurship, so what kind of model could support people at different levels of interest in business?
- Empowerment has to be intentional, said one participant, but in order to incorporate it, a business case often needs to be made. At the same time, it is not something that can be given, but develops from within through multilayered conversations and expansion of opportunities.
- Health is not just the business of government, but also of the private sector, communities, professionals, and most importantly the families (particularly the women in those families).
- One participant stated that it is not enough to demonstrate a model works. For the model to thrive and have impact within a health system, it needs to be sustainable.
- Providing universal health coverage would involve a paradigm shift from acute care to community-based primary health care. This could result in more coordinated care in which nurses and midwives play a critical role particularly as an entry point into the health system.
- Academic institutions can be critical partners in sharing knowledge and mobilizing resources. How can institutes of higher education in Africa, Asia, and elsewhere link up with innovative enterprise models? How can both collaborate with the public sector?
- Incubators do not always capture data that could potentially be used for scaling up innovative models in different settings.
- Results-based financing can be a platform for autonomy and accountability and potentially for scalability.



# Appendix A

## Workshop Agenda

**EMPOWERING WOMEN AND STRENGTHENING  
HEALTH SYSTEMS AND SERVICES THROUGH  
INVESTING IN NURSING AND MIDWIFERY ENTERPRISE:  
LESSONS FROM LOWER-INCOME COUNTRIES**

**A Public Workshop of the Global Forum on Innovation in  
Health Professional Education, in partnership with the Forum  
on Public–Private Partnerships for Global Health and Safety**

**September 9–11, 2014**

**The Rockefeller Bellagio Center  
Bellagio (Lago di Como), Italy**

**Workshop Objective:**

To discuss, explore, and explicate from a variety of perspectives the investment in nursing and midwifery enterprise and the associated education/training innovations from lower-income countries as means for empowering women and strengthening health services and systems both globally and in the United States.

**DAY 1: TUESDAY, SEPTEMBER 9, 2014**

**SESSION I: Setting the Stage and Exploring Intersections**

8:00am      **BREAKFAST**

9:00am      **Workshop background, overview, and objectives**  
Marla Salmon, Chair



## Session I Objectives:

To create a shared foundation of knowledge, insights, and information that will enable discussion and deliberation, focusing on:

- Workshop impact targets overview:
  - Women’s empowerment in the global context
  - Strengthening health systems and services in the global context
- Nursing and midwifery in the global context overview:
  - Education/training and practice in the global context
  - Nursing and midwifery enterprise—role and forces shaping their development

**Part 1: The impact targets: Empowering women and strengthening health systems and services**

- 9:45am      **Women’s empowerment:** What’s happening, what’s been working, where are the challenges, where does social enterprise and investment fit in this space?  
An overall perspective on women’s empowerment  
Moderator and presenter: Diệp Vương
- Presenter 1: Monique Dolfing-Vogelenzang  
Q&A
  - Presenter 2: Beth Bafford  
Q&A
- Discussion**  
What are the important lessons in women’s empowerment, and how do/might they intersect with/influence health systems and services?
- 10:45am      **BREAK**
- 11:00am      **Strengthening health systems:** What are the drivers, what are the key trends, what opportunities are available (global and United States)?  
Moderator: Mary Barger
- Presenter 1: Akiko Maeda  
Q&A
  - Presenter 2: Krishna Udayakumar  
Q&A
- Concluding comments: Oscar Picazo  
Q&A
- Discussion**  
Other perspectives and key takeaways

**Part 2: Key elements and intersections: Nursing and midwifery**

- 12:00pm **Nursing and midwifery education/training and enterprise:**  
 Women's empowerment and strengthening of health systems  
 in lower-income countries  
 Setting the stage: Mary Barger, moderator and presenter  
 Overview presentations:  
 • Barbara Parfitt (via Skype)  
 Q&A  
 • Petra ten Hoope-Bender  
 Q&A  
**Discussion**
- 1:00pm **LUNCH**
- 2:00pm **Country perspectives:** Akiko Maeda, moderator  
 • Amal Abu Awad  
 • Emilia Iwu  
 • Julie Fairman  
**Q&A/Discussion (mini groups of 3–4 discuss and report  
 back)**  
 How does nursing/midwifery training and enterprise  
 intersect/influence women's empowerment and health  
 systems strengthening?
- 3:00pm **Nursing and midwifery enterprise—models and lessons  
 learned:** What it is, what is happening in lower-income  
 countries, and what we are learning?  
 Moderator and co-presenter: Gina Lagomarsino  
 Presenter: Carleigh Krubiner  
**Q&A**
- 4:00pm **BREAK**
- 4:20pm **Discussion**  
 • What can be learned that might inform approaches to  
 improving impacts on women's empowerment and health  
 systems strengthening?  
 • What might enhance the impact of these individual  
 models?

- 4:30pm      **Key “takeaways”:** Each person states 1–3 important points from the day’s discussions  
Moderator: Marla Salmon
- 5:30pm      **ADJOURNMENT**
- 7:00pm      **DINNER**—Small groups  
**Discussion groups:** Two “fast break, round robin” groups will be formed for more focused discussion over dinner to brainstorm opportunities for translation of “models and lessons learned” to other regions and countries, as well as to the United States.  
Group I: The global context; Group II: U.S. specific  
Perspectives will be noted and shared briefly.  
Moderator: Marla Salmon

## DAY 2: WEDNESDAY, SEPTEMBER 10, 2014

### SESSION II: Innovations and Strategies for Improving Women’s Empowerment While Strengthening Health Systems

- 8:00am      **BREAKFAST**
- 9:00am      **Recap, review objectives, and small group assignments**  
Moderator: Marla Salmon

#### Session II Objectives:

To create a shared foundation of knowledge, insights, and information that will enable discussion and deliberation, focusing on:

- Health systems/service innovations and organizational strategies
- Investment and other support strategies for start-up, scaling, and sustainability

- 9:20am      **Innovations and organizational strategies that strengthen health services/systems and empower women:** What we are learning about what *works* and *what doesn’t*  
Moderator: Susan Kosman
- Presenter 1: Monique Dolfing-Vogelenzang  
Q&A
  - Presenter 2: Molly Coye  
Q&A

- Presenter 3: Krishna Udayakumar

#### Q&A

Concluding comments: Susan Kosman

#### Q&A and Discussion

What innovations and organizational approaches will help nursing and midwifery enterprise strengthen health systems and services while empowering women?

10:30am **BREAK**

11:00am **Social enterprise and investment in health:** What works and what it takes

Overview and moderator: Krishna Udayakumar

- Oscar Picazo
- Beth Bafford
- Lakshmi Karan (video)

#### Q&A and Discussion

What approaches to social finance and building social enterprise will enable nursing and midwifery enterprise that strengthens health systems/services while empowering women?

### SESSION III: Transferability of Models and Lessons Learned

Session III Objective:

To explore potential transferability of models and lessons learned to new settings, including considerations relating to context, health-related needs, populations, and culture

12:00pm **Break into three small groups: Phase 1**

Process: Two conveners per group; participants move in cohorts through three groups

- Identify challenges, opportunities, enablers, and barriers relating to the nursing and midwifery enterprise innovations/enterprises
- Identify strategies for success in developing, financing, and sustaining innovative practices

**Group 1 Leaders: Julie Fairman and Monique Dolfig-Vogelenzang**

*Challenges and opportunities:* Developing financing nursing and midwifery enterprises that empower women and strengthen health systems

**Group 2 Leaders: Diệp Vương and Krishna Udayakumar**

*Promising approaches/models:* Bringing together the key elements of nursing/midwifery practice and education/training; and social enterprise/social finance in ways that could maximize women's empowerment and health systems/services strengthening

**Group 3 Leaders: Susan Kosman and Akiko Maeda**

*Strategies and support:* Start-up, scale-up, sustainability, and transferability of actual and theoretical models globally and to the United States

1:00pm LUNCH

2:00pm Small groups: Phase 2—circulate

2:45pm Small groups: Final phase 3—circulate

3:30pm BREAK—Process small groups

4:00pm Presentations (with Q&A) by Three Group Leaders

Moderator: Marla Salmon

- Group 1: Monique Dolfig-Vogelenzang
- Group 2: Krishna Udayakumar
- Group 3: Akiko Maeda

4:45pm Commentary: Deborah Bae  
Seed thinking for messages for United States

5:15 pm ADJOURNMENT

**DAY 3: THURSDAY, SEPTEMBER 11, 2014****SESSION IV: Key Messages and Models for the  
United States and the Larger Global Context**

- 8:00am **BREAKFAST**
- 9:00am **Focus for impact: Insights from the past 2 days**  
Moderator: Marla Salmon
- 9:15am **The Ghana Project**  
Highlights and insights: Monique Dolfing-Vogelenzang  
Q&A
- 10:00am **Small groups: Models and making them work**  
Moderator: Marla Salmon
- 11:00am **BREAK**
- 11:15am **Report backs**
- 12:00pm **The Way Forward**
- An open discussion for sharing of individual perspectives
  - What are the key messages, lessons learned, and next steps?
  - Moonshot review
  - Dissemination of the final report
- 1:00pm **LUNCH AND ADJOURNMENT**



## Appendix B

### Speaker Biographical Sketches

**Amal Muhammad Rashid Abu-Awad, Ph.D., R.N., M.S.N.**, is currently the dean of Ibn Sina College; in addition, she was assigned in September 2012 as the acting general director of continuing and higher health education at the Palestinian Ministry of Health. She has been a registered nurse since 1987. In 1992 she received a master's degree from the United States in Neonatal and Pediatric Nursing. Abu-Awad worked 2.5 years in the neonatal unit at Makassed Hospital in Jerusalem and had also worked for 3.5 years in the Continuing Education Department at Makassed Hospital. In 1994 she completed a postgraduate diploma as instructor in Continuing Education from Bethlehem University. While at Bethlehem University for 3 years she was a coordinator and instructor for three neonatal programs. In 1998 she updated her clinical experience in the Neonatal Unit at Shaare Zedek Medical Center in Jerusalem. In 1999, Abu-Awad joined Ibn Sina College as a director for the nursing baccalaureate program and stayed in the position for 5 years. In 2004, she became the vice dean for academic affairs; she was then promoted to be the dean of the college in 2006. In 2008, she received the Fulbright scholarship, and joined the Ph.D. program at the University of Wisconsin–Madison with a major in nursing and a minor in education leadership and policy analysis, completing the Ph.D. program in December 2011. Her research interests focus on linking education and practice to improve the health outcomes of mothers and infants.

Currently, she works on multiple projects. The first is transforming nursing curriculum to integrate the essential competencies, palliative and advanced geriatrics. Second is establishing online resource centers at all Ministry of Health (MOH) hospitals with online courses using the Moodle



system. Third is establishing a systematic primary trauma care course for health providers within MOH. Fourth is having a systematic orientation program for new MOH employees including nurses, midwives, and physicians.

**Deborah Bae, M.P.A., M.B.A.**, joined the Robert Wood Johnson Foundation in 2005 and is interested in discovering and exploring innovative ideas, novel approaches, and new ways of thinking and then sharing the learnings both within the foundation and beyond. Her areas of interest include finding innovative health solutions from around the world to improve health care in the United States and the role of design in improving health outcomes. Previously, Bae worked in the New York City Department of Health Bureau of Informatics and Data Services, helping to implement an electronic disease reporting system for all New York City hospitals and laboratories. She also was a microbiology laboratory research assistant at the University of Pennsylvania. Bae received her M.P.A. and M.B.A. from New York University and her B.A. from Bryn Mawr College in Pennsylvania.

**Beth Bafford, M.B.A.**, is a senior officer of Strategic Initiatives at the Calvert Foundation, where she focuses on enterprise strategy, partnership development, fundraising, and capital deployment for current and future investment initiatives. Her main areas of investment focus are health care—both global and domestic—and place-based community development.

Prior to joining the Calvert Foundation, Bafford was a manager in McKinsey & Company's Washington, DC, office where she focused mostly on U.S. health reform strategy for large health insurers, academic medical centers, and hospital systems. She has also worked as a special assistant at the White House Office of Management and Budget during the drafting and passage of the Affordable Care Act, as a regional field director for the 2008 Obama for America campaign, and as a senior associate at UBS Financial Services.

Bafford received both her B.A. in public policy and M.B.A. in social entrepreneurship from Duke University. At Duke's Fuqua School of Business she helped launch the Center for the Advancement of Social Entrepreneurship (CASE) Initiative on Impact Investing (CASE i3), the first comprehensive program on impact investing at a top business school. In 2012, Bafford started a professional women's network called The Square Pegs to create an open dialogue around women's issues and challenges for young females in the workplace.

**Mary Barger, Ph.D., M.P.H., CNM, FACNM**, experiences of growing up in the Middle East shaped her intense interest in maternal and child health as well as sparked her interest in midwifery. She combined these passions

by receiving a master's of public health and her nurse-midwifery training from Johns Hopkins Bloomberg School of Public Health after receiving her nursing degree from Stanford University and spending time as a nurse in Saudi Arabia and a refugee camp in Jordan. She furthered her interest in perinatal epidemiology through obtaining a Ph.D. in epidemiology from Boston University. Clinically, Barger has practiced nurse-midwifery for an interdisciplinary comprehensive pregnancy program for low-income women in San Diego, provided care to Navy dependents through the Balboa Naval Medical System, and worked at a multispecialty practice in Boston, Massachusetts. She has held faculty positions at the University of California, San Diego, Department of Community and Family Medicine; Boston University School of Public Health Department of Maternal and Child Health; and the University of California, San Francisco, Family Health Care Nursing. She served as a nurse-midwifery codirector for the University of California, San Francisco/University California, San Diego, Intercampus Program and director of the Boston University Nurse-Midwifery Program. In the areas of education and certification, Barger is a recognized leader. She currently serves on the board of the American Midwifery Certification Board and is chair of the Continuing Competency Program; she has been responsible for major changes in competency requirements for midwives. She was a leader in adding primary care to the midwifery core competencies for the American College of Nurse-Midwives. She has served on the examination committees for the National Certification Corporation and the Board of Public Health Examiners. Barger has participated in a Fulbright Interprofessional Health project with health faculty in Malawi. Currently, she is a co-chair of the Education Standing Committee for the International Confederation of Midwives. Barger is a Fellow of the American College of Nurse-Midwives.

**Molly Joel Coye, M.D., M.P.H.**, is the chief innovation officer of University of California, Los Angeles (UCLA), Health and heads the Institute for Innovation in Health and the Global Lab for Innovation at UCLA, where she leads the health system in identifying new strategies, technologies, products, and services to support the large-scale transformation of health care. The Global Lab for Innovation advances the international exchange of health delivery innovations that enable dramatic improvements in access to and affordability of health services. Coye also advises technology developers, investors, national health systems and policy makers about disruptive technologies and business models that accelerate transformation and constrain health expenditures.

Coye was the founder and CEO of the Health Technology Center (HealthTech), a nonprofit education and research organization established in 2000 that became the premier forecasting organization for emerging technologies in health care. Coye has also served as commissioner of health

for the State of New Jersey, director of the California State Department of Health Services, and head of the Division of Public Health Practice at the Johns Hopkins School of Hygiene and Public Health. Coye is an elected member of the Institute of Medicine (IOM), and a member of the Board of Directors of Aetna Inc.; Prosetta Biosciences, Inc.; Big White Wall; and the American Telemedicine Association. She has previously served as chair of the Board of Directors of PATH, one of the largest nonprofit organizations in global health, and on the boards of the American Hospital Association, the American Public Health Association, Cholestech, Inc., The California Endowment, and the China Medical Board, as well as the advisory boards of venture and private equity firms investing in health care information technology and services. Coye holds M.D. and M.P.H. degrees from Johns Hopkins University and an M.A. in Chinese History from Stanford University, and is the author of two books on China.

**Monique Dolfing-Vogelenzang, LLM**, is managing director of the Medical Credit Fund (MCF). She joined PharmAccess Foundation, a Dutch not-for-profit organization dedicated to the strengthening of health systems in sub-Saharan Africa in early 2008. At PharmAccess, Dolfing-Vogelenzang was responsible for the development and the launch of the MCF. She secured its start-up capital and realized its financing round of \$30 million with large international public and private investors, including OPIC, Soros Economic Development Fund, the Calvert Foundation, and The Bill & Melinda Gates Foundation. The MCF is the first fund to provide small and medium-size enterprise (SME) loans to private primary health care facilities in Africa, linked to measurement of quality improvement using the SafeCare methodology. It won the G-20 SME Finance Challenge award in 2010 as well as an OPIC Impact Award for Access to Finance in 2014. Medical Credit Fund is currently expanding significantly in Kenya, Ghana, Nigeria, and Tanzania. Prior to her work on the MCF, Dolfing-Vogelenzang held a variety of senior management positions in the private sector, predominantly related to complex information technology projects for large financial institutions. She holds a master's in law from the University of Leiden, the Netherlands.

**Julie A. Fairman, Ph.D., R.N., FAAN**, is a nurse historian whose work on the history of 20th-century health care represents a track record of consistent funding, including fellowships from the National Library of Medicine, National Endowment for the Humanities, and Robert Wood Johnson Foundation (RWJF). Her work on the history of critical care earned her awards from the American Association of the History of Nursing and her first book *Critical Nursing: A History* received favorable reviews in the national and regional popular press and from reviewers in professional journals. Her most recent book is *Making Room in the Clinic: Nurse Practitioners and*

*the Evolution of Modern Health Care* is in its second printing and recently out in paperback. She is currently the director of the Barbara Bates Center for the Study of the History of Nursing, and is working on a history of the intersection of health policy and nurse practitioners in the United States from 1980 to the present.

Fairman's research focuses on the history of 20th-century health care issues pervading contemporary nursing practice. Much of her recent work addresses the relationship between gender, nursing and technology (critical care), and the history of the social construction of professional boundaries (the history of the nurse practitioner movement). This research has been used by members of Congress and by other policy making bodies such as the Ministry of Health of New Zealand. She is currently investigating the influence of the nursing profession on health policy and looking at the role of the patient as health policy advocate. Other work examines the post-World War II history of nursing scholarship and disciplinary development. Fairman serves as the 2009 IOM/American Academy of Nursing/ American Nurses Foundation Scholar in Residence and will work with the RWJF/ IOM Commission on Investing in the Future of Nursing.

Fairman does not currently hold a clinical appointment but has worked with groups of practicing nurse practitioners through invitations to dialogue in journal clubs or think tanks, and collaborative work with clinician educator colleagues. As a former chair of a University of Pennsylvania institutional review board, she necessarily kept current with clinical topics, and was responsible for maintaining strict standards of public protection during clinical research at the University of Pennsylvania.

**Emilia Iwu, R.N., M.S.N., APNC, FWACN**, completed her basic nursing and midwifery education in Nigeria. She obtained a bachelor's degree in school health services from Rowan University of New Jersey, and another undergraduate and graduate degree in Nursing from Rutgers University of New Jersey. Before joining University of Maryland's Institute of Human Virology and School of Nursing as technical advisor for the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) grant in Nigeria, she worked as a family nurse practitioner in the Infectious Diseases Clinic at Cooper Hospital University Medical Center and Healthcare for the Homeless Program, both in Camden, New Jersey. Her key interests have been capacity development of nurses through education and practice.

As assistant professor at the School of Nursing, University of Maryland, Iwu helped design a postmasters global health certificate program that involves clinical and research rotations for U.S.-based nursing students in Nigeria and other resource-constrained countries. Her research interests include nurses' work and safety, nurses' roles in changing health care delivery in resource-constrained countries, patient access and retention in care, as

well as the impact of mentored training for health care workers on quality of care provision. She is currently enrolled in a Ph.D. in Nursing program at Rutgers. Building on her global health work in Nigeria, Iwu's Ph.D. project interest is to study "the impact of task shifting on nurses, quality of care, and professional regulatory policies."

**Lakshmi Karan, Ph.D., M.S.**, brings multisector, global expertise in strategy, philanthropy, social entrepreneurship, and impact assessment. Most recently she was the global strategy director at Riders for Health, an award-winning social enterprise that delivers transportation solutions to millions in Africa. Prior to this she was the Skoll Foundation's director of impact assessment and learning, where she guided program strategy, development, and evaluation of investments totaling more than \$100 million. Karan has also served as adviser to global nonprofits and corporations. In the private sector, she was a technologist and business consultant to Fortune 500 companies. Karan holds a master's in computer science from the National Institute of Information Technology (India) and a master's and a Ph.D. in international relations from the Fletcher School at Tufts University. She is on the Boards of Potential Energy (formerly Darfur Stoves) and Maitri (South Asian domestic violence shelter). Karan serves as a judge on several social entrepreneurship competitions (Echoing Green, Global Social Venture Competition, and Canadian Government's Grand Challenges in Health).

**Susan Kosman, R.N., M.S.**, is the chief nursing officer for Aetna Inc. She is responsible for Aetna's nursing strategy, which includes developing and promoting a culture of high performance and engagement, workforce planning, and leadership development. Kosman is also responsible for the following functional and service areas within National Care Management: clinical training; quality review and auditing; medical management systems; program design for utilization management, case management, disease management, behavioral health, wellness and eHealth; and National Account custom care unit operations.

Kosman began her career with Aetna in 1995 as manager of government programs for the Northeast Region. In 1998, Kosman joined core health delivery operations hospital and provider contracting as manager for quality and audit. She returned to the Northeast region from 1999 to 2002 as director of patient management. Prior to joining Aetna, Kosman spent 10 years in the home health industry in various roles.

Kosman is a Board Member of the Aetna Foundation, Chair of the American Heart Association, Greater Hartford chapter, and the Connecticut League for Nursing. She is on the advisory boards of the Hartford Health Sciences Academy and the Goodwin College B.S.N. and Higher Degree board. Kosman also represents Aetna at the Center to Champion

Nursing Coalition. She holds a B.S. in nursing from SUNY Downstate, an M.S. in organizational leadership from Quinnipiac University, and is a D.N.P. candidate at Sacred Heart University.

**Carleigh Krubiner, Ph.D.(c)**, is a doctoral candidate in bioethics and health policy in the Department of Health Policy and Management at Johns Hopkins Berman Institute of Bioethics. Her research interests include the ethics of health incentive programs, international health, health systems strengthening in low- and middle-income countries, resource allocation, and HIV/AIDS policy. Her dissertation research focuses on the ethical design of conditional cash transfer programs targeting health behaviors in developing countries.

Prior to coming to Hopkins, Krubiner was a research associate at the Results for Development Institute in Washington, DC, where she worked on the aids2031 Costs and Financing Project as well as other HIV/AIDS-related research in association with the Global Fund. Krubiner previously worked as a research associate at the Advisory Board Company, providing customized research reports on best practices for hospitals surrounding clinical quality and operational efficiency. Krubiner received her B.A. from the University of Pennsylvania in 2006, majoring in the history and sociology of science.

**Gina Lagomarsino, M.B.A.**, is a principal, chief operating officer, and managing director at Results for Development Institute (R4D) with a focus on health system design and financing. She leads work aimed at expanding health coverage in low- and middle-income countries, with a particular interest in how to create vibrant health markets that include high-quality, innovative private care providers that are accessible to people regardless of income. Lagomarsino leads the Center for Health Market Innovations, which has discovered more than 1,000 innovative programs with potential to improve quality and affordability of care for the poor in 110 countries, and she is now working to facilitate the scale-up of successful programs. Lagomarsino is also the Secretariat lead and a cofounder of the Joint Learning Network for Universal Health Coverage, a network of policy makers in low- and middle-income countries working to accelerate the successful adoption of national health insurance reforms. Prior to joining R4D, Lagomarsino was senior health policy advisor to Washington, DC, Mayor Anthony Williams, where she worked to reform the health system of the District of Columbia. She designed and implemented a managed care reform of a public health insurance program serving low-income DC residents. She also spearheaded the District's effort to implement the medical homes initiative to expand and improve the quality of private community health centers. Prior to her work in government, Lagomarsino was an en-

agement manager in the Healthcare Practice of McKinsey & Company, where she advised senior executives of health insurance and hospital organizations on strategy and operations. She also worked for Kaiser Permanente, a private integrated financing and delivery system, based in the state of California, where she implemented a new model of primary care at a large multispecialty medical center and served as a market research consultant for Kaiser insurance products. Lagomarsino received a master's in business administration from Harvard University and a bachelor's degree in public policy from Stanford University.

**Akiko Maeda, Ph.D., M.A.**, currently holds the position of lead health specialist at the Health, Nutrition and Population Department of The World Bank. She is currently leading The World Bank's strategy on Human Resources for Health for Universal Health Coverage. Maeda has more than 20 years of development experience in health and social programs, and has provided policy advice to senior government officials and assisted in the design of health policy reform and health projects in the Middle East, North Africa, Asia, and Europe. Her areas of expertise include health insurance and health financing reforms, health services reorganization, and human resources for health. Before joining The World Bank, Maeda held various positions with the Asian Development Bank (in the Philippines), UNICEF (United Nations Children's Fund, in Cambodia and Yemen), and UNDP (United Nations Development Programme, in Yemen). She has a Ph.D. in health economics from Johns Hopkins Bloomberg School of Public Health; an M.A. in biochemistry and molecular biology from Harvard University; an M.A. in Middle Eastern studies also from Harvard University; and a bachelor's degree in biochemistry from Princeton University.

**Barbara Parfitt, CBE, Ph.D., RGN, RM, FNP**, carried out her initial nurse training at the Queen Elizabeth School of Nursing in Birmingham, UK. She gained experience on a general medical ward and then continued into midwifery working as a nurse midwife in Worcester and Leicestershire. After studying theology for 3 years in London, she worked overseas for 10 years in international health development in Afghanistan, Nepal, Bhutan, and Turkey. Her main role at this time was as a nurse practitioner and midwife. Following the completion of a nurse practitioner program in Indianapolis, Indiana, she returned to the United Kingdom and studied for a master's in international community health in 1979 at Liverpool School of Tropical Medicine, Liverpool University. She then went on to undertake an M.Sc. and a Ph.D. in nursing at Manchester University. Her Ph.D. studies explored international primary health care focusing on the impact of the Western values of nurses on primary health care development in developing countries.



She then continued to focus her research on international health with completed projects in Turkey and Jordan. She was appointed as professor and dean of the School of Nursing Midwifery and Community Health at Glasgow Caledonian University (GCU) in 1995 until February 2007 when she stepped aside to undertake a new role as director of the Caledonian Centre for Global Health. She is also the director of the WHO Collaborating Centre for Nursing and Midwifery Education, Research and Practice in GCU. She was appointed as the secretary general of the WHO Collaborating Centres for Nursing & Midwifery Development Global Network Secretariat in July 2004. In this position, she supports the work of 38 collaborating centers worldwide. These centers seek to achieve the goal of strengthening nursing and midwifery.

In addition to international development, she has a keen interest in the importance of spirituality within the healing process and the values that underpin the caring role. She continues with a research focus in international health and her current research and practice development activities include the evaluation of the family health nursing in Tajikistan and Scotland. She is also currently working on international nursing and midwifery development projects in the Central Asian region. Parfitt was awarded a CBE in the Queen's new honors list in January 2007 for services rendered to international health development.

**Oscar F. Picazo** has worked in more than 23 countries on health economics, financing and policy, and human resources for health as staff of The World Bank (10 years) and the U.S. Agency for International Development (7 years), and as an independent consultant. He has written about 60 technical reports on global health problems and issues, 30 of which have been published. He is senior research consultant, Philippine Institute for Development Studies, Legazpi Village, Makati City, Philippines. He currently serves as an Executive Board Member, Health Research Hub, Department of Health, and is also a member of the Study Group on Hospital Systems in Asia, Asia-Pacific Observatory (APO) on Health Systems and Policy. Picazo was a consultant to the Chairman of the Board, Philippine Health Insurance Corporation, Pasig City, Philippines; Chair, Philippine NGO Support, Inc., Quezon City, Philippines; lecturer, Health Economics for Managers, Ateneo de Manila Graduate School of Business, Rockwell, and Makati City, Philippines; and is president, Rotary Club of Makati, Rockwell, District 3830.

**Marla Salmon, Sc.D., R.N., FAAN**, is Senior Visiting Fellow at the Evans School of Public Affairs, and Professor of Nursing and Public Health at the University of Washington (UW). She has served as dean of nursing at both UW and Emory University, and as a faculty member in nursing and/or public health at the University of Pennsylvania, University of North



Carolina at Chapel Hill, and the University of Minnesota. Focusing on global and domestic health policy and workforce development, Salmon's career has included a number of governmental and policy leadership roles, including: director of the Division of Nursing with the U.S. Department of Health and Human Services; chair of the National Advisory Committee for Nursing Education and Practice; member of the Clinton administration's White House Taskforce on Healthcare Reform; member of the U.S. Delegation to the World Health Organization; and member of the National Institute for Nursing Research National Advisory Committee. She was recently appointed to the Special Medical Advisory Committee for the U.S. Department of Veterans Affairs.

Salmon's international service roles have focused on health workforce capacity building and include chair of the Global Advisory Group for Nursing and Midwifery, World Health Organization; head of the Secretariat for the Global Government Chief Nursing Officers Network; and founding director of the Lillian Carter Center for International Nursing, Emory University. She has been a consultant/advisor to individual governments and global health bodies, including the World Health Organization; the Pan American Health Organization; the Caribbean Community Secretariat; the Commonwealth Health Ministries Steering Committee for Nursing and Midwifery, the Regional Nursing Body of the Caribbean; and the U.S. Centers for Disease Control and Prevention. Currently serving on the board of directors for the Institute for Education of Students Abroad (IES) and the Gretta Foundation, Salmon is a trustee emeritus for the Robert Wood Johnson Foundation. She is a member of the IOM, where she has served on a number of committees, including the IOM's Committee on Envisioning a Strategy to Prepare for the Long-term Burden of HIV/AIDS: African Needs and the U.S. Interests.

Salmon's publications include the award-winning book *NURSE: A World of Care*, which documents the role and impact of nursing around the world. She has been recognized with numerous national awards, including a 2008 Book of the Year award from the *American Journal of Nursing*. She is also the recipient of numerous other national and international awards and recognitions. Salmon received her doctorate in health policy and administration from the Johns Hopkins School of Hygiene and Public Health, where she continues to serve on the Deans Advisory Committee. She also holds degrees in nursing and political science, and studied national health insurance in Germany and Kuwait as a Fulbright Scholar.

**Petra ten Hoope-Bender, R.N., M.B.A.**, is the Instituto de Cooperación Social Integrare (ICS Integrare) Director and formerly the Institute's Director for Reproductive, Maternal, Newborn and Child Health (RMNCH). She is a midwife and executive manager with a health professional and busi-

ness administration background and 20 years of experience in independent midwifery and the management and development of organizations and public–private partnerships in the international health arena. She is the former interim director of the Partnership for MNCH (PMNCH), and the secretary general of the International Confederation of Midwives (ICM). She also served as the co-chair of the Inter-Agency Group on Safe Motherhood, the predecessor to the PMNCH, and was one of the key managers of the transition from Safe Motherhood to Maternal, Newborn and Child Health.

**Krishna Udayakumar, M.D., M.B.A.**, leads multiple initiatives at Duke Medicine in the rapidly evolving fields of health innovation and globalization of health care. As head of Global Innovation for Duke Medicine, he is responsible for the development and implementation of global strategy as well as global business development for Duke Medicine, across health care delivery, biomedical sciences research, and health professions education and training. Udayakumar has also led the International Partnership for Innovative Healthcare Delivery (IPIHD), a nonprofit co-founded by Duke Medicine, McKinsey & Company, and the World Economic Forum, since its inception in 2011. As executive director, he leads all aspects of IPIHD’s work to support the scale and replication of transformative health solutions globally.

He also serves as co–principal investigator for the Social Entrepreneurship Accelerator at Duke (SEAD), a Duke-wide partnership with USAID that seeks to create an integrated global health social entrepreneurship hub for diverse stakeholders across the globe. In addition, he continues to be a key driver of broader health innovation efforts at Duke, serving as director of the Center for Health Delivery Science within the Duke Institute for Health Innovation. At Duke University, Udayakumar holds the rank of associate professor of global health and medicine, and also holds a faculty appointment at Duke-National University of Singapore Graduate Medical School Singapore. His work has been published in leading academic journals such as the *New England Journal of Medicine*, *Health Affairs*, and *Academic Medicine*.

Born in Bangalore, India, Udayakumar spent his childhood in Virginia, and is a Phi Beta Kappa graduate of the University of Virginia, with a bachelor’s degree in interdisciplinary studies with distinction. He received both an M.D. from the Duke University School of Medicine and an M.B.A. (with a concentration in health sector management) from the Fuqua School of Business at Duke University, where he was a Fuqua Scholar. Udayakumar completed his residency training in internal medicine at Duke and served as assistant chief resident at the Durham VA Medical Center before joining the faculty of Duke University.

**Diệp N. Vương, Ph.D.**, co-founded Pacific Links Foundation (PALS) and currently serves as president. Since the early 1990s, she has focused her effort on poverty alleviation and community participation for multilateral agencies such as The World Bank, UNDP, and international nongovernmental organizations. Under Vương's leadership, PALS has articulated its focus on women empowerment through innovative and grassroots programs, from community leadership to antihuman trafficking. Since 2005, Vương designed and spearheaded ADAPT (An giang/Dong thap Alliance for the Prevention of Trafficking). Stateside, Vương has consulted for the County of Santa Clara to build capacity for its nonprofit contractors. She also accumulated experience in the private sector through positions with Silicon Valley high-tech companies, urban planning firms, and financial firms including Morgan Stanley. Vương is a cum laude graduate of Harvard University, San Jose State University, and pursued her Ph.D. coursework at the University of California, Berkeley.

## Appendix C

### List of Participants

**Marla Salmon** (*Chair*)  
University of Washington

**Amal Muhammad Rashid  
Abu-Awad**  
Palestinian Ministry of Health;  
Ibn Sina College for Health  
Sciences, East Jerusalem

**Deborah Bae**  
Robert Wood Johnson Foundation

**Beth Bafford**  
Strategic Initiatives  
Calvert Foundation

**Mary Barger**  
University of San Diego;  
American College of  
Nurse-Midwives

**Molly Joel Coye**  
Ronald Reagan UCLA Medical  
Center  
University of California, Los  
Angeles (UCLA)

**Monique Dolfing-Vogelenzang**  
Medical Credit Fund  
Stichting Medical Credit Fund

**Julie A. Fairman**  
University of Pennsylvania School  
of Nursing

**Emilia Iwu**  
PEPFAR in Abuja, Nigeria

**Lakshmi Karan<sup>1</sup>**  
Charitable Giving  
Genentech

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<sup>1</sup> Lakshmi Karan provided video recorded comments at the meeting.

**Susan Kosman**

Aetna Inc.

**Carleigh Krubiner<sup>2</sup>**

Johns Hopkins Bloomberg School  
of Public Health

**Gina Lagomarsino**

Results for Development Institute  
(R4D)

**Akiko Maeda**

Health, Nutrition and Population  
Network  
The World Bank

**Address Malata<sup>3</sup>**

Kamuzu College of Nursing  
University of Malawi

**Barbara Parfitt<sup>4</sup>**

Global Health Development  
Glasgow Caledonian University

**Liesbet D. Peeters<sup>3</sup>**

D. Capital Partners  
A Dalberg Group Company

**Oscar Picazo**

Philippine Institute for  
Development Studies (PIDS)

**Petra ten Hoop-Bender**

Reproductive, Maternal, Newborn  
and Child Health

ICS Integrare (Instituto de  
Cooperación Social Integrare)

**Krishna Udayakumar**

International Partnership for  
Innovative Healthcare Delivery  
(IPIHD)

**Diệp N. Vuong**

Pacific Links Foundation

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<sup>2</sup> Carleigh Krubiner was an in-person guest presenter for the meeting.

<sup>3</sup> Address Malata and Liesbet Peeters did not attend the meeting in person.

<sup>4</sup> Barbara Parfitt was a virtual guest presenter for the meeting.

## Appendix D

# Innovations in the Provision of Health Services Using Empowered Nurses and Midwives in the Philippines<sup>1</sup>

*Oscar F. Picazo,<sup>2</sup> Valerie Gilbert T. Ulep, Ida Pantig, Danica Ortiz, Melanie Aldeon, and Nina Ashley de la Cruz<sup>3</sup>*  
September 9–11, 2014

### INTRODUCTION

The Philippines is a large-scale producer of nurses and midwives for both domestic employment and export. However, as advanced countries (e.g., the United States) decided to expand domestic nursing education, Filipino graduates increasingly found it difficult to find overseas employment especially in lucrative destinations like Australia, Canada, the United States, and Western Europe.

Interestingly, although there has been a domestic glut of Filipino nurses for some time, many rural and peri-urban areas in the country remained unserved or underserved with health personnel, resulting in weak improvement in national child health status and a setback in the reduction of maternal mortality ratio. This has been mainly because of the low pay of health personnel in poorer areas, which also stems from the inadequate

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<sup>1</sup> Paper prepared for the Institute of Medicine's Workshop on "Empowering Women and Strengthening Health Systems and Services Through Investing in Nursing and Midwifery Enterprise: Lessons from Lower-Income Countries," The Rockefeller Bellagio Center, Bellagio, Italy, September 9–11, 2014. This paper relies on the findings of the nationwide search for Health Market Innovations (HMI) in the Philippines that was given a grant by The Rockefeller Foundation through the Center for Health Market Innovations (CHMI) of the Results for Development (R4D) in Washington, DC.

<sup>2</sup> Senior research consultant, the Philippine Institute for Development Studies (PIDS). More information at [www.pids.gov](http://www.pids.gov).

<sup>3</sup> PIDS staff involved in documenting case studies in the Health Market Innovations (HMI) Project in the Philippines.

third-party payment system that should make the employment of nurses and midwives in these areas more attractive on a personal level, and more sustainable on a health system perspective.

In recent years, several private-sector initiatives have emerged focusing on the deployment of nurses and midwives to underserved areas, and employing more sustainable business models. This paper profiles four major innovations using nurse or midwife empowerment as a basis, and focusing on the health needs of the poor and near-poor. These health market innovations are:

- the Well-Family Midwife Franchise Clinics;
- the Mother Bles Birthing Clinics, a public–private partnership;
- the Blue Star Pilipinas Clinics; and
- the EntrepreNurse Cooperatives.

### WELL-FAMILY MIDWIFE FRANCHISE CLINICS

Improved quality of maternal and reproductive health care is necessary to decrease the high level of maternal and infant mortality. Given the vibrant role of the private providers in the health care system, they can serve as an instrument in delivering quality and standardized maternal and child care services. The Well-Family Midwife Clinic (WFMC) was put up in 1997 by the John Snow Institute Research and Training Institute, which specializes in providing technical assistance to public health programs around the world.

WFMC was initiated under the Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Services by Philippine Nongovernmental Organization (NGO), or TANGO for short. The U.S. Agency for International Development (USAID) provided support for piloting this franchise. The Philippines was deemed appropriate for this type of business model because of (a) the surplus of available and trainable health service providers (midwives), (b) the existence of a segment of the population willing and able to pay for services, and (c) popular demand for quality health services, as revealed in demographic and health surveys.

WFMC envisions affordable and accessible quality health care for every Filipino by providing entrepreneurial opportunities to midwives who have established linkages with their respective communities. It operates as a social franchise that offers a “one-stop” shop for family planning and maternal and child health services targeting lower- and middle-income families. Social franchising works in much the same way as commercial franchising by applying the latter’s strategies to the health sector to efficiently expand access to quality health care to underserved communities; the only difference is the initial subsidy (in development costs, training, and information

campaign) that a social franchise gets from a sponsor (external or local donor or government), which a business franchise does not get.

The WFMC clinics are equipped with birthing facilities and private examination rooms for pregnancy tests, minor gynecological services such as Pap smear, basic health services of a midwife such as normal spontaneous delivery, pre- and post-natal care, and immunization services. At present, there are 120 WFMCs located in Metro Manila and in 28 provinces all over the country.

The franchise network of WFMC has translated to effective delivery of services because of the quality standards set. These standards were provided under the technical assistance and business training given to the midwives initially by the TANGO project and thereafter by the successive franchisor-NGO that was put up for the purpose after the TANGO project ended. By being part of the WFMC network, midwife-franchisees are also assured to receive technical updates which contribute to the effective service delivery in the clinics.

The benefits have translated not only to a significant number of mothers and children who receive quality health services, but also to the midwife-turned-entrepreneurs who have modestly increased their income by running the clinics instead of only being on-call. Thus, the WFMC has successfully evolved to become an autonomous, self-sustaining franchise system, revolving around the midwife-entrepreneurs.

The social franchise scheme of WFMC has scaled up access to quality health care especially for the people in rural areas. Social franchising is indeed one of the innovative ways in which the need for family planning and maternal and child services of the underserved population can be met.

### MOTHER BLES BIRTHING CLINICS

Maternal mortality ratio in the Philippines is targeted to be reduced by three-quarters by 2015; this is equivalent to 52 maternal deaths per 100,000 live births. However, the country is not on track to meet this target. Indeed, in 2009, maternal mortality ratio was recorded to be 169 per 100,000 live births, and there was even a significant increase in the ratio in 2011 to 221/100,000). Aside from maternal deaths in married women, teenage pregnancy has also increased.

The problem of maternal deaths in the Philippines is mainly due to poor access to affordable and high-quality facility-based maternity care services. Many pregnant mothers live too far from a health facility with basic maternal and obstetric care. This situation leaves no option for many poor mothers but to rely on traditional attendants for giving birth.

To address this severe lack of birthing facilities, Sister Eloisa David of Kakak Foundation Inc. (a local NGO) and Governor Carlos Jericho



Petilla launched the Mother Bles Birthing Clinics (MBBCs) in Leyte Province, one of the highly underserved local government units in the country. MBBC is a public–private partnership (PPP) initiative that provides a solution to the poor maternal health and infant care services among the lower- and middle-income mothers in the province. MBBCs are networks of PhilHealth-accredited birthing facilities that offer affordable and accessible professional obstetric and other medical assistance to clients.

MBBCs systematically select the areas in the province with high maternal mortality ratio. This problem-identification stage is deemed crucial, as the location of a clinic is very critical in maternal mortality reduction programs. The appraisal and the construction of the clinic is followed by negotiation and arrangement with the *barangay* (village) or the municipality for clinic space. In most cases, the clinic space is the contribution of the local government unit in the PPP. The training of midwives is provided by MBBC in partnership with the Private Practicing Midwives (a local NGO group), while the operation of the clinic is undertaken by Kakak Foundation.

The MBBCs offer a variety of services focusing on maternal, family planning and reproductive health. These include prenatal care, nutrition and family planning, PhilHealth enrollment assistance, postnatal care, guidance counseling and catechism, and registration of live births, baptisms, and even validation of marriage for unwed couples.

With the determination to provide affordable and quality maternal and infant health care services to the poor, Mother Bles has established 50 clinics in 3 years from 2010 to 2013: 4 in Pampanga, 2 in Bataan, 3 in Cebu, 6 in Northern Samar, 2 in Western Samar, 24 in Leyte, 2 in Southern Leyte, 1 in Antique, 2 in Misamis Oriental, and 4 in Bukidnon.

Mother Bles has also constructed the Mother Bles Learning Center as its corporate social responsibility. It also donated a multi-media room to Palo Central Public School and a multicab to a far flung barangay in Lonoy, Maasin, Southern Leyte, so that mothers can be brought to the town center. Mother Bles has also sponsored the training of 43 midwives as scholars to be deployed in these clinics.

### BLUE STAR PILIPINAS CLINICS

Blue Star was launched in 2008 as a nonprofit network of clinics providing reproductive health services in the Philippines. The social marketing network is organized as a franchise arrangement with the license and accreditation being provided by the franchisor, Blue Star. Blue Star's parent organization is Population Services Pilipinas, Inc. (PSPI), a nonprofit company. The clinics provide family planning, reproductive health, HIV/AIDS prevention, maternal health, and newborn and child health services, targeting the bottom 20 percent of the Philippine population.

The franchises are run by licensed midwives (1 midwife per clinic) in 200 clinics. To ensure quality, Marie Stopes International trains Blue Star providers in state-of-the-art service delivery and then regularly monitors quality to ensure that agreed standards are met. Providers receive training in areas such as family planning knowledge, counseling, clinical skills, marketing, and business management. Existing private facilities are refurbished and rebranded with a Blue Star logo, and are then promoted to clients to assist them in identifying and accessing quality services. Franchises are able to buy family planning contraceptives for their centers at reduced prices, ensuring better profit margins.

To participate in the network, the midwife-franchisees pay an annual membership fee of US\$24 and weekly fee of US\$7, which covers PSPI's initial investment for the franchise clinics and midwife-operator, including training and initial supplies and equipment. The fee also covers Blue Star Pilipinas' management cost in running and enhancing its operations as franchisor.

Accreditation of providers and facilities of PhilHealth's Maternity Care Package has entitled Blue Star's franchisee-midwives to claim US\$120 in reimbursement for each delivery of a PhilHealth enrolled woman, which helps franchised-midwives cover operating costs.

Quality assurance and performance monitoring methods include (a) site visits (six per year) and internal audits (twice per year); (b) external audits (once per year); (c) client exit interviews (once per year); (d) qualitative reviews with clients (twice per year); and (e) qualitative reviews with providers. The business systems audit verifies client numbers and service statistics that are reported by the franchisees. Blue Star uses these findings to improve the reporting mechanisms.

## ENTREPRENURSE COOPERATIVES

The Region XI Office of the Department of Labor and Employment initiated *EntrepreNurse* in 2010 to address the pressing problem of unemployment among local nurses and to provide adequate public health workforce and services to the people of Davao Region. In the late 2000s, graduate nurses had exceeded more than 150,000 R.N.s/B.S.N.s nationwide, the glut resulting from the narrowing of the market of nurses in the United States and other advanced countries and the inability of local nursing production to adjust accordingly.

In collaboration with the Department of Health and PhilHealth, the *EntrepreNurse* Project aimed to increase the employment of nursing graduates by training them on entrepreneurial management and organizing them into cooperatives of nurse-run clinics that offer reduced cost of primary and home health care services to indigent or poor rural households.

EntrepreNurse cooperatives were piloted in the communities of Davao City, Davao del Sur (Digos City), Davao del Norte (Tagum City), Davao Oriental (Mati), and Compostella Valley. The capitalization of these cooperatives comes directly from their members while the pieces of clinic equipment are provided for by the Department of Labor and Employment.

The main purpose of the nurse cooperatives is to deliver home and primary health care services. Other services were added later, including medical transcription, emergency medical services, tourism health services, wellness and fitness management for private companies, outsourcing of nursing health services for private establishments, medical mission management for private companies and local government units, and periodic physical examination of workers for private companies.

The strategy is to deploy recruited nurses to barangays (one nurse per barangay per month) with serious public health problems, as identified by the local government units and the regional Department of Health office. During the barangay (village) visit, the nurse-member of the cooperative will do health education and care provision and will be paid PHP1,000 per visit by the sponsoring organization, which can be the local government, PhilHealth, the local Congressman, or a donor. Each cooperative should have at least one experienced head nurse to oversee its operations.

The entrepreneurial training of nurses is given prior to their becoming cooperative members, and it involves orientation on cooperative principles, the salient features of R.A. 9520 (the Act on Cooperatives), membership fees and subscriptions, duties and responsibilities of cooperative members, and benefits of cooperativism. The number of nurse-cooperative members per province in the Davao Region ranges from 30 to 60. There are 65 nurses registered in Davao Oriental, 23 in Davao City, and 30 in both Davao del Norte and Compostela Valley. Five EntrepreNurse cooperatives have been organized, one each in the following areas: Davao Oriental (Mati), Compostela Valley, Davao del Norte (Tagum City), Davao del Sur (Digos City), and Davao City.

## CONCLUSIONS:

### WHAT MAKES THEM WORK? WHAT ARE THE CONSTRAINTS?

The five cases described in this paper involve innovative ways of deploying health workers (nurses for the most part) to underserved areas. What makes these innovations work?

- Availability of nurses and midwives—The Philippines produces hundreds of thousands of nurses and midwives per year. Thus, there is a ready supply of these health workers. Traditionally, these have worked in government and private hospitals and outpatient

clinics, or with NGO health programs, but since the 1990s there have been increasing flows forming their own practices.

- Leadership and initial investment support—These innovations were invariably started by individuals with entrepreneurial streak (e.g., Sister Eloisa of Mother Bles Clinics) or by donors or NGOs (USAID, Marie Stopes International) led by strong Filipino leaders. Leadership, of course, is idiosyncratic and hard to replicate.
- PhilHealth reimbursement for facility-based delivery—Although the initial impetus for these innovations was not driven by PhilHealth (the social health insurance program), the expansion of PhilHealth benefits to include safe motherhood and selected reproductive health services gave strong incentives for their growth. The government policy requiring all mothers to deliver in health facilities also helped. With the enactment of the Reproductive Health Law, it is anticipated that many more nurse-led health services will bloom. This will gain traction through the expected approval of wider primary care benefits under PhilHealth.

What have been the constraints for these types of innovations to start or to thrive?

- Regulatory obstacles and bureaucratic delays—It takes nearly 18 months and up to 2 years to get a license to operate a small social health enterprise (pharmacy, clinic) from the regulatory agencies (Food and Drug Administration, Department of Health Center for Health Development) and business permit from local government units. There is little sense of urgency among these regulatory agencies to expedite the processing of a license to operate and a business permit.
- Professional turf issues—Physicians, especially obstetricians and gynecologists (affiliated with the Philippine Obstetrics and Gynecological Society), often lock horns with nursing and midwifery groups (or individuals) over their respective scopes of professional practice as well as patient-clients. Some physicians feel threatened by the increasing role and market share of nurses and midwives in such services as antenatal and post-natal care, safe delivery, and reproductive health.
- Inadequate training of nurses and midwives on management—Some observers have noted that the education of nurses in the Philippines is too oriented at their being caregivers rather than being care-managers. The existing training programs also tend to underplay the importance of professional autonomy among nurses.

